



## Ending Gender-Based Violence in South Sudan

- Fighting back against GBV
  - Clinical management of rape
  - One Stop Centre
  - 16 Days of Activism
  - Talk about Men4Women
  - Ask the GBV experts
  - Girl child story
  - GBV resources
- PLUS:**
- Survival of preterm neonates
  - Maternal death factors

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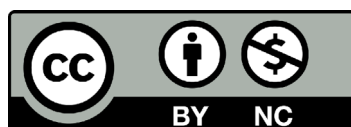
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**EDITORIAL**

- Ending GBV in South Sudan [Anne Pita Lomole](#) ..... 124

**RESEARCH ARTICLES**

- Maternal socio-economic and neonatal medical characteristics associated with survival of preterm neonates in Torit State Hospital, South Sudan: a descriptive cross-sectional study [Beatrice Doki, Pontius Bayo and Ronald Jada](#) ..... 126
- Factors associated with maternal deaths in Bongor Provincial Hospital, Chad [Gabkika Bray Madoué, Allarehene Noudjalbaye, Saleh Abdelsalam, Kainba Passoret, and Diguisna Kadam](#) ..... 133

**FOCUS ON GENDER-BASED VIOLENCE**

- Gender-Based Violence: How South Sudan is fighting back [Nyakomi Adwok](#) ..... 137
- Clinical management of rape survivors [Koma Akim](#) ..... 141
- One Stop Centre for the survivors of sexual and gender-based violence at Juba Teaching Hospital [Busiri Julius Korsuk](#) ..... 144
- SSMJ talks to Data Gordon about Men4Women [Ann Burgess and Data Gordon](#) .. 145
- Ask the GBV experts [Koma Akim and Nyakomi Adwok](#) ..... 149
- The reality of GBV: The story of a South Sudanese girl child in Kenya [Nyajuok Tongyik](#) ..... 151
- 16 Days of Activism Against GBV [Rita Martin Lopidia](#) ..... 153
- Resources on gender-based violence / violence against women and girls related to South Sudan ..... 154
- GBV Educational/Training Resources ..... 157

**SHORT COMMUNICATIONS**

- Applications for Postgraduate Training Gordon Memorial College Trust Fund (GMCTF) ..... 131
- Letter to the Editor ..... 159
- Obituary: Dr Bashir Aggrey Abbas Meseka ..... 160
- Obituary: Dr Peter Lado Aggrey Jaden ..... 161

**FRONT AND BACK COVERS IMAGES:** Images from the book Tales of Lala, No to GBV (Credit: Crown the Woman, South Sudan)

# Ending GBV in South Sudan

This special issue of the South Sudan Medical Journal is mainly devoted to addressing the problem of gender-based violence especially as it affects women and girls. Gender-based violence (GBV) is defined as violence committed against a person because of their sex or gender. It is forcing another person to do something against their will through violence, coercion, threats, deception, cultural expectations, or economic means.<sup>[1]</sup> GBV disproportionately affects girls and women. The global statistics indicate that 1 in 3 of women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.<sup>[1]</sup>

A recent study in South Sudan, conducted by The Sudd Institute, shows that substantial proportions of women in South Sudan experience GBV either in form of physical (34.0%) or sexual (13.5%) violence in their lifetime.<sup>[2]</sup> Intimate Partner Violence is at 49.6%, the second highest in the region.<sup>[2]</sup> Similarly, the study documented a high prevalence of child marriage (34.6%) nationally.<sup>[2]</sup> These numbers are concerning as it indicates that not enough is being done to prevent and address GBV in South Sudan. The situation may be even worse with the large numbers of women and girls returning from Sudan. As a signatory to the Maputo Protocol<sup>[3]</sup> that seeks to end all forms of gender inequality, this is unacceptable.

GBV is detrimental to women's mental, physical, sexual, and reproductive health.<sup>[4]</sup> It can lead to depression, post-traumatic stress, anxiety disorders, and suicide attempts.<sup>[4]</sup> Physical injuries and fatal outcomes like homicide can also result from GBV.<sup>[4]</sup> It can also lead to unintended pregnancy, abortion and its complications, obstetric fistula, miscarriage, and increased risk of STIs.<sup>[3]</sup> GBV has great social and economic costs for countries as it can lead to women being isolated, unable to work and lacking participation in society.<sup>[4]</sup>

According to a 2021 report, discriminatory social norms, a weak legal system, and power inequalities are among the core drivers of GBV in South Sudan.<sup>[5]</sup> Its findings revealed that GBV victims have very minimal or no access to justice and healthcare, which is associated with factors such as lack of resources, customary practices, lack of capacity of legal and health actors, and lack of knowledge of their own rights by victims.<sup>[5]</sup>

Prevention of GBV and its effects on survivors, requires a multidisciplinary approach that ensures policies are put in place and reforms of policy and legislation are done, to ensure protection for GBV survivors.<sup>[5]</sup> Justice and legal redress should be enforced. Dissemination of information and awareness to the target communities to enable them to understand their rights and seek redress is necessary.<sup>[5]</sup> Continued advocacy to change social norms and practices that promote GBV and ensure accountability is essential.<sup>[5]</sup>

GBV is  
detrimental to  
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and  
reproductive  
health

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Healthcare and rehabilitation services for the survivors must be prioritized by strengthening health systems' capacity to integrate GBV services at primary health service points and ensure survivor and person-centred GBV services.<sup>[6]</sup> Coaching, mentorship, and job aids should be offered to health workers at all levels of the health system, to ensure survivor-centred care across sexual and reproductive health and rights services.<sup>[6]</sup> Sensitization of health care workers on GBV and handling of GBV cases should also be done.<sup>[6]</sup>

The Ministry of Health, UN agencies, NGOs and other partners have focused on multisectoral approaches to reducing GBV, including coordinated interventions to ensure timely and safe respectful services to survivors.<sup>[7]</sup> These include women's empowerment, and building the capacity of health, psychosocial and legal sectors to handle GBV cases. It also means making protection against GBV central to humanitarian policy and operation and building the capacity of the civil society.<sup>[7]</sup>

Healthcare workers must not take a back seat to GBV prevention and management as many of its consequences have both direct and indirect effects on health, with transgenerational impact. As healthcare workers, we must be an integral part of the fight to end this affront to Human Rights.

### **Dr Anne Pita Lomole**

The Karen Hospital Nairobi and The South Sudanese Women's Intellectuals Forum

Correspondence: [pitaanne@gmail.com](mailto:pitaanne@gmail.com)

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# Maternal socio-economic and neonatal medical characteristics associated with survival of preterm neonates in Torit State Hospital, South Sudan: a descriptive cross-sectional study

Beatrice Doki,<sup>1</sup> Pontius Bayo<sup>2</sup> and Ronald Jada<sup>3</sup>

1. Department of Obstetrics and Gynaecology, St Pauls Hospital Millennium Medical College, Ethiopia
2. Department of Obstetrics and Gynaecology, Torit State Hospital, South Sudan
3. Nimule County Hospital, South Sudan

Correspondence:

Beatrice Doki [dwokilaku@gmail.com](mailto:dwokilaku@gmail.com)

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## ABSTRACT

**Introduction:** One in 10 babies is born preterm globally. Preterm birth is a major cause of mortality among children under 5 years old especially in sub-Saharan Africa. The socio-economic and clinical characteristics associated with survival of preterm babies admitted in Torit State Hospital are unknown. This study describes these characteristics to inform quality-of-care initiatives to improve preterm neonatal care.

**Method:** A retrospective study was conducted of the medical records of 67 preterm neonates admitted from 1st January to 31st December 2021. Neonatal outcome at discharge was recorded as alive, dead, or absconded while neonatal clinical and maternal socio-economic characteristics were recorded as independent variables. The data were analysed using SPSS Statistics software version 21. Descriptive statistics including frequencies and proportions were calculated. Differences in the proportions were tested using the chi-squared statistic. All significance levels were set at  $p \leq 0.05$ .

**Results:** Of the 67 preterm babies admitted, 47 (70.1%) were discharged alive with a significant increase in body weight, 18 (26.9%) died and the outcomes of two patients were not recorded. The ability to suckle at the time of admission ( $p=0.01$ ) and having a mother educated to at least primary level ( $p=0.035$ ) were significantly associated with higher preterm survival.

**Conclusions:** Premature mortality was common among preterm babies who were not able to suckle at the time of admission and lack of formal maternal education was associated with low survival rates. Educating girls to at least primary level can contribute significantly to preterm neonatal survival.

**Key words:** preterm, neonates, maternal characteristics, maternal education, Torit State Hospital, South Sudan

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## INTRODUCTION

Deaths among under-5 year old children have reduced significantly in recent years but this reduction has been slow for deaths during the neonatal period.<sup>[1]</sup> Neonatal deaths contribute up to 53.1% of all deaths among children aged under five in low and middle-income countries.<sup>[2]</sup> Complications due to preterm birth constitute a major cause (36%) of neonatal deaths.<sup>[3]</sup> Globally 15 million babies are born preterm every year (1 in 10 babies born) and about one million of these die<sup>[1]</sup> while many who survive face lifetime disability including cerebral palsy, learning disabilities, visual and hearing problems, and respiratory illness.<sup>[4,5]</sup> The World Health Organization (WHO) defines a preterm birth as babies born before 37 **completed** weeks of pregnancy.<sup>[4]</sup>

There is inequality in survival of preterm neonates depending on where they are born. While more than 50% of those born in low-income countries will die, almost all survive in the high-income countries.<sup>[4]</sup> The many risk factors for preterm births in low-income countries include high rates of teenage pregnancy,<sup>[6]</sup> heavy physical work,<sup>[7]</sup> single mothers,<sup>[8]</sup> poor socio-economic status of the mother,<sup>[9]</sup> and short pregnancy intervals.<sup>[10]</sup> Others include obstetric risk factors such as antepartum haemorrhage, diabetes mellitus, preeclampsia, intrauterine growth retardation, preterm premature rupture of membranes, multiple pregnancies, and maternal infections that are also more frequent in low-income countries.<sup>[5,11]</sup>

Preterm birth rates in South Sudan were reported to have increased from 12% in 2014 to 13% in 2017, a total of 59,000 preterm babies.<sup>[12]</sup> While 1,300 of these babies survived with a disability, 4,600 died directly from preterm complications.<sup>[13]</sup>

The first 24 hours of a neonate's life are critical,<sup>[14]</sup> therefore, safe and timely care is needed during the intra-partum and immediate post-partum periods. Evidence shows that clean birth practices during the intra-partum period reduces neonatal mortality due to sepsis by 38% while during the post-natal period neonatal resuscitation reduces mortality by 30-38%, early breastfeeding initiation by 44% and management of hypothermia by 10-20%.<sup>[15,16]</sup> However, the availability and access to such care is limited in South Sudan as the protracted political conflict in the country has left large gaps in the health care system.<sup>[17]</sup> A national health facility survey in 2014 indicated that only one in four health facilities in South Sudan had the basic supplies and equipment for neonatal care.<sup>[18]</sup> There is a severe shortage of health workers as training schools were not functional for a long time<sup>[19]</sup> and skilled health workers attend only 19% of births.<sup>[20]</sup> Where services exist there is limited information on their quality and their impact on the survival of the preterm neonate.

One study carried out in a displaced people's camp in South Sudan indicated that midwives spent only 6.2% of their time on postnatal care.<sup>[21]</sup> In this study none of the essential new-born care elements was practiced consistently: thermal care practice was at 62.5%, infection prevention at 74.8%, feeding support at 63.6% and post-natal monitoring at only 27.7%. The study did not indicate how much of this care was different for the preterm neonates.

The aim of this study was to describe the maternal socio-economic and neonatal clinical characteristics associated with the survival of preterm neonates admitted to the neonatal unit in Torit State Hospital. It is hoped that the results of this study will be useful to partners and policy makers.

## METHOD

### Study design

This was a retrospective study involving the review of medical records in Torit State Hospital's Neonatal Unit in the department of Obstetrics and Gynaecology. Routine data of all preterm neonates admitted in the unit from 1st January to 31st December 2021 were reviewed (N=67).

### Study setting

Torit State Hospital is the only major referral hospital in Eastern Equatoria State. While Torit County, with an estimated population of 238,000,<sup>[22]</sup> is the main catchment area, the hospital serves five other surrounding counties as a referral point for complicated medical cases including preterm underweight neonates. The hospital has a 140-bed capacity. The Neonatal Unit offers basic neonatal care, it has four electric baby warmers and oxygen concentrators but it lacks capacity for advanced respiratory support such as mechanical ventilation, continuous positive airway pressure (CPAP), surfactant therapy and exchange transfusion. Babies who require such advanced care are referred to Juba Teaching Hospital.

The unit adapted a WHO standard protocol to guide admissions and treatment for neonates.<sup>[23]</sup> Criteria for admission for preterm neonates included babies born before 34 weeks of gestation and/or those with a birthweight of less than 1.8 kg. Preterm babies weighing between 1.8 and 2.5 kg would be admitted only if they had other medical conditions such as respiratory distress, neurological problems such as seizures, or impaired consciousness. The criteria for discharge included weight gain of 1.8 kg or more and absence / resolution of all other medical conditions.

### Study population

All preterm and low birth weight neonates admitted to the hospital's neonatal unit were included. A preterm neonate was defined as a neonate delivered before gestational age 37 weeks based on calculation from the last menstrual period reported by the mother and low birth weight (LBW) as less than 2.5 kg.

### Data collection

We developed a data collection tool which was used by the nurse-in-charge, to extract data from patient files based on maternal socio-economic and neonatal clinical characteristics that affect the survival of preterm births.<sup>[11, 24, 25]</sup> and the first author (BD) reviewed and validated the data.

The main outcome variable was survival while those who absconded were excluded. The independent variables

included the mother's age, education, marital status, employment, and place of birth, as well as the neonate's weight, any febrile illness (defined as body temperature above 38°C and/or presence of local sepsis such as cord infection) and mode of feeding at the time of admission, presence of any congenital abnormalities, and other treatment given. The APGAR (synonym for appearance, pulse, grimace, activity, and respiration)<sup>[26]</sup> score at admission and whether baby received treatment with oxygen, aminophylline and incubator and/or Kangaroo mother care (KMC) were recorded.

### Data management and analysis

The data were analysed using SPSS Statistics software. Descriptive statistics including frequencies and proportions were calculated. Statistical significance of the difference in the proportions of preterm neonates who survived versus those who died were tested using the chi-squared statistic. Significance levels were set at  $p \leq 0.05$ .

### Ethical considerations

Ethical clearance was sought from the State Ministry of Health Ethical Board and permission to retrieve the data was granted by the hospital authorities. Only initials were included as identifiers on the data collection forms and data were password locked.

## RESULTS

### Characteristics of the participants

Of the 67 preterm babies who were admitted during the study period, 47 (70.1%) were discharged alive, while 18 (26.9%) died, and the outcomes of two were not recorded (Table 1). Fifty (74.6%) were health facility births, all but one (98.5%) weighed more than 1 kg, but less than 2.5 kg. At admission only 42 (62.7%) were breastfeeding, 44 (65.7%) were febrile and three (4.5%) had congenital abnormalities. Twenty (29.9%) of the babies had an APGAR score of less than 7 while 14 (20.9%) had no information recorded regarding their APGAR score. Only 23 (34.4%) received oxygen therapy, 33 (49.2%) received aminophylline and 22 (32.8%) received care in baby warmers and/or through KMC. Fifty-nine (88.1%) were born to mothers aged above 18 years, 77.6% of the mothers had either not gone to school at all or stopped at primary level and only nine mothers (13.4%) had formal employment.

### Characteristics of neonates discharged alive compared to those who died.

Table 2 shows the characteristics of neonates who died compared to those discharged alive. There was no difference in terms of maternal age, marital status, and

employment status of the mothers in the two groups. However, the neonates of mothers who had some formal education were more likely to survive than those whose mothers had no formal education at all ( $p=0.035$ ).

Mortality was significantly higher among babies who were not able to suckle breast milk at the time of admission ( $p=0.001$ ) and among those who had medical conditions, other than a febrile illness, although this difference was not statistically significant. Survival was significantly higher among babies who had APGAR scores of 7 or more ( $p=0.001$ ) and therefore, did not need treatment with oxygen ( $p=0.013$ ).

## DISCUSSION

This study sought to determine the maternal social and neonatal medical characteristics that may affect preterm neonatal survival in Torit State Hospital. We found a preterm neonatal mortality rate of 26.9%, which is similar to findings in other studies in the region: in Uganda 31.6%,<sup>[27]</sup> and 22.2% in northern Ethiopia,<sup>[28]</sup> and 27.6% in Ghana.<sup>[29]</sup>

The survival of a preterm neonate is related to the birthweight and gestation age with survival being particularly low if the birth weight is less than 1kg and/or gestation age is less than 28 weeks, especially in the developing world where resources for care are limited.<sup>[30, 31]</sup>

The babies of educated mothers were more likely to survive than those of uneducated mothers. It has been established that early neonatal deaths are an indicator of poor social condition of families and populations.<sup>[32]</sup> But it has also been noted that maternal education significantly determined neonatal survival even after controlling for other important factors such as socio-economic characteristics of the male partner.<sup>[33]</sup>

This study also showed a significantly high neonatal mortality among those that were not suckling breast milk at the time of admission. Poor suckling, which leads to hypoglycemia, is a common cause of death among premature babies.<sup>[13,23]</sup> Therefore, premature babies need additional feeding and nutritional support through either IV fluids or nasogastric tube feeds<sup>[13]</sup> and healthcare providers need to be trained to be able to provide this care.

In this study, there were more deaths among those born at home than those born at a health facility although this was not statistically significant due to small number of the study.

This study used routine medical data to inform continuous quality improvement initiatives of the hospital and its implementing partners. South Sudan is coming out of prolonged civil war, the health system structures are still under development. Our study aims to stimulate local efforts to improve directly the quality of neonatal data



Table 1. Characteristics of participants

Participant characteristics		n (%)	Participant characteristics		n (%)
Mother's age in years	<18	8 (11.9)	Birth weight	≤1 kg	1 (1.5)
	≥18	59 (88.1)		>1 - <2.5 kg	66 (98.5)
Mother's level of education	Primary	28 (41.8)	APGAR Score at admission	<7	20 (29.9)
	Secondary	12 (17.9)		≥7	33 (49.2)
	University	3 (4.5)		No information	14 (20.9)
	Not gone to School	24 (35.8)	Baby breastfeeding	Yes	42 (62.7%)
Mother's occupation	No formal employment	33 (49.3)		No	25 (37.3)
	Formally employment	9 (13.4)	Presence of congenital abnormalities	Yes	3 (4.5)
	No information	25 (37.3)		No	64 (95.5)
Mother's marital status	Single	3 (4.5)	Baby given oxygen treatment	Yes	23 (34.3)
	Married	64 (95.5)	No	44 (65.7)	
Mother's Parity	≤4	30 (44.8)	Baby given aminophylline treatment	Yes	33 (49.2)
	>4	30 (44.8)		No	30 (44.8)
	No information	7 (10.4)		No information	4 (6.0)
Baby's medical condition at ad-mission	Febrile illness	44 (65.7)	Baby received care in baby warm-er and/or Kangaroo mother care	Yes	22 (32.8)
	Other illness	7 (10.4)		No	45 (67.2)
	No other illness	16 (23.9)		Outcome at discharge	Alive
Place of birth	Home	17 (25.4)	Died		18 (26.9)
	Health facility	50 (74.6)	Escaped/ Lost to follow-up		2 (3.0)
Gestation age at birth	≤28 weeks	1 (1.5)			
	>28 weeks	58 (86.6)			
	No information	8 (11.9)			

**Table 2. Maternal social and neonatal medical characteristics of preterm neonates who were discharged alive compared with those who died**

Maternal social and neonatal medical characteristics		Alive n (%)	Died n (%)	p-value
Maternal age (years)	≤ 18	6 (75.0)	2 (25.0)	0.856
	>18	41 (71.9)	16 (28.1)	
Mother's employment status	No formal employment	24 (75)	8 (25)	0.095
	Formally employed	9 (100)	0 (0)	
Mother's education level	Some formal education	34 (81)	8 (19)	0.035
	No education at all	13 (56.5)	10 (43.5)	
Mother's marital status	Single	2 (66.7)	1 (33.3)	0.823
	Married	45 (72.6)	17 (27.4)	
Gestational age in weeks	≤ 28	1 (100)	0 (0)	0.569
	>28	43 (75.4)	14 (24.6)	
Baby's condition at admission	Febrile illness	36 (76.6)	7 (38.9)	0.057
	Other illness	3 (6.4)	4 (22.2)	
	No other illness	8 (17.0)	7 (38.9)	
Place of birth	Home births	10 (58.8)	7 (41.2)	0.148
	Health facility births	37 (77.1)	11 (27.7)	
Breast feeding/suckling	Yes	36 (85.7)	6 (14.3)	0.001
	No	11 (47.8)	12 (52.2)	
APGAR score at admission	<7	10 (52.6)	9 (47.4)	0.001
	≥7	31 (93.9)	2 (6.1)	
	No information	6 (46.2)	7 (53.8)	
Baby treated with oxygen	Yes	11 (52.4)	10 (47.6)	0.013
	No	36 (81.8)	8 (18.2)	
Baby treated with aminophylline	Yes	21 (67.7)	10 (32.3)	0.393
	No	22 (73.3)	8 (26.7)	
	No information	4 (100.0)	0 (0)	
Baby received care in baby warmer and/or Kangaroo mother care	Yes	12 (57.1)	9 (42.9)	0.059
	No	35 (79.5)	9 (20.5)	

collection and the quality of care for preterm neonates.

The study had limitations. The sample size was small, and some variables were often missing or unusable. Lastly, although a standard protocol is available for the care of preterm babies, it was not possible to ascertain if all the patients received the same standard of care.

## CONCLUSION

Preterm neonatal mortality at Torit State Hospital is high among those whose mothers have no formal education. The inability to suckle breast milk at admission was associated with high risk of death. Girls' education should be prioritized as they are future mothers. Preterm neonates who are not able to suckle at admission require extra care from providers to improve chances for survival.

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## Applications for postgraduate Training Gordon Memorial College Trust Fund (GMCTF)

**Dr Eluzai Hakim**

Member, Executive Committee of the GMCTF

This is to remind applicants for GMCTF grants for the academic year 2023/2024 that applications for grants close on 28th February 2024.

All applications must be made online through the following website [www.gmctf.org](http://www.gmctf.org) and must be accompanied with two letters of reference one of which must be from a referee in the area of study.

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GMCTF encourages female applicants and applicants in non-medical fields as well.



# Factors associated with maternal deaths in Bongor Provincial Hospital, Chad

Gabkika Bray Madoué,<sup>1,2</sup> Allarehene Noudjalbaye,<sup>2</sup> Saleh Abdelsalam,<sup>1,2</sup> Kainba Passoret,<sup>1</sup> and Diguina Kadam<sup>1</sup>

1. N'Djamena Faculty of Health Sciences, Chad
2. N'Djamena Mother and Child University Hospital, Chad

**Correspondence:**

Gabkika Bray Madoué [kickbray@yahoo.fr](mailto:kickbray@yahoo.fr)

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## ABSTRACT

**Introduction:** Maternal mortality remains a major public health problem, particularly in Chad. The aim of this study was to analyse the factors associated with maternal death.

**Method:** This was a retrospective descriptive and analytical study conducted at Bongor Provincial Hospital (BPH) over a 5-year period (2015 to 2020). The study population consisted of all maternity patients who died in this hospital and whose records were complete. The variables studied were epidemiological, clinical, and therapeutic factors. The data were collected and analysed using Sphinx Plus<sup>2</sup>(V5) software. The Chi-square test was used to compare the variables. A p-value of less than 0.05 was considered significant.

**Results:** We registered 13,758 women with all pathologies, of which 6,349 met the inclusion criteria; 98 of them died (1.5%) giving a Maternal Mortality Rate (MMR) of 1005/100,000 live births. These deaths mainly occurred in women aged between 20 and 24 years (30.6%), who were married (79.6%), housewives (59.2%), multiparous (33.7%), from rural areas (74.5%), uneducated (39.8%) and who had had no prenatal care (60.2%). The main aetiologies reported were: genital haemorrhage (77.5%), infections (63.3%), malaria (61.2%), severe anaemia (39.8%) and dystocia (25.5%).

**Conclusion:** Maternal mortality is a major health problem, and its reduction requires the mobilization of all actors in society and implies good health education, improvement of the quality of prenatal follow-up and emergency obstetric care.

**Keywords:** maternal death, Bognor Provincial Hospital, Chad.

## INTRODUCTION

Maternal death refers to the death of a woman during pregnancy or within 42 days of termination, regardless of duration or location, from any cause determined or aggravated by the pregnancy or its management, but not accidental.<sup>[1]</sup> Global estimates for 2017 indicate that there were 295,000 maternal deaths, 35% less than in 2000 when they were estimated at 451,000, of which 86% (254,000) were in sub-Saharan Africa and South Asia.<sup>[2]</sup> According to 2015 statistical data, the maternal mortality ratio (MMR) in Chad is 860 deaths per 10,000 live births and the causes are multifactorial.<sup>[3]</sup> The MMR is similar in Mayo-Kebbi Est Province.

The death of a woman of childbearing age is a significant economic loss for both family and community. Several strategies have been developed to reduce maternal mortality, including family planning, emergency obstetric and neonatal care (EmONC) and skilled birth attendants.<sup>[3]</sup>

Few studies have addressed the factors associated with maternal deaths in the province of Mayo-Kebbi Est, which is why we conducted this one at Bongor

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Provincial Hospital (BPH), which is the reference care site for the populations of Mayo-Kebbi Est in Chad and Yagoua in Cameroon.

**METHOD**

This retrospective descriptive and analytical study took place over two months from 1 January 2015 to 31 December 2020 in the maternity ward of BPH.

It examined the clinical records of women who died in the maternity service of BPH during pregnancy, delivery, post-abortion and postpartum, as well as those of live births registered during the study period. Studied variables were epidemiological, clinical, and therapeutic factors.

Data were entered and analysed using Sphinx Plus 2 .v5 software and EXCEL 2010 software. Chi square and p-value statistical tests were used with a p-value <0.05 considered significant.

**RESULTS**

During the study period, 13,758 patients were admitted. Only 6,349 had complete records. Out of these 98 (1.5%) died.

The age group 20 to 24 years was more represented with 30.6%. The median age was 23.6 ± 6.6 years with a range of 14 to 42 years. (Table 1). Fifty-seven (58.1%) of the women who died were aged 24 years or below.

Nearly half the patients, 45.9% (n=45), reported having no education and respectively 24.5% (n=24), 23.5% (n=23) and 6.1% (n=6) had primary, secondary and university education. Most (74.5%.) came from rural areas and 80.6%.(n=77) were married.

One third of the patients were multiparous of whom 27.6% (n=27) were grandmultiparous ( ≥ 5), 13.3% (n=13) were primiparous and 15.3% (n=15) were pauciparous. Most, 69.4% (n = 68), were referred from facilities outside BPH. Table 2 shows that 60% of the women had had no prenatal contacts. Fifty-four of the deaths (55.1%) occurred in the postpartum period. (Table 3) For 24 (24.5%) labour was the entry diagnosis. (Table 4) Haemorrhage was the direct obstetric cause of death for 67.4% (n = 66) women; others include pre-eclampsia/eclampsia 10% (10.2), infection 9% (9.2), abortion 8%(8.1) and obstructed labour 5% (5.1). Malaria was the most frequent indirect cause of death for 61.2% (n = 60) women. (Table 5) The hospital stay was 24 hours or less for 55.1% (n = 54) of the women, between 24 – 48 hours for 23.5% (n=23) and more than 48 hours for 21.4% (n=21).

**DISCUSSION**

During the study period, the maternity service recorded

**Table 1. Age distribution of the women who died (N=98)**

Age (year)	Frequency n (%)
≤19	27(27.5)
20-24	30 (30.6)
25-29	21 (21.4)
30-34	13 (13.3)
35-39	4 (4.1)
≥40	3 (3.1)
<b>Total</b>	<b>98 (100)</b>

**Table 2. Number of prenatal contacts**

Antenatal consultations	Frequency n (%)
0	59 (60.2)
≤3	35 (35.7)
4-6	3 (3.1)
7-8	1(1)
<b>Total</b>	<b>98 (100)</b>

**Table 3. Stage of pregnancy when death occurred**

Stage of pregnancy	Frequency n (%)
During pregnancy	12 (12.4)
Post-abortion	26 (26.5)
During childbirth	6 (6.1)
During the first 24 hours postpartum	39 (39.8)
After 24 hours postpartum	15 (15.3)
<b>Total</b>	<b>98 (100)</b>

**Table 4. Distribution according to entry diagnosis on admission**

Diagnosis at admission	Frequency n (%)
Postpartum haemorrhage	14 (14.3)
Endometritis	19 (19.4)
Malaria	21 (21.4)
Abortion	14 (14.3)
Eclampsia	8 (8.2)
Pre-term labour	18 (18.4)
Labour and delivery	24 (24.5)
Ectopic pregnancy	8 (8.2)
Molar pregnancy	6(6.1)
Uterine rupture	2 (2)
Placenta praevia	2 (2)

**Table 5. Distribution according to indirect causes of death**

Indirect causes of death	Frequency n (%)
Post-operative complications	12 (12.2)
Post-partum cardiomyopathy	10 (10.2)
Kidney diseases	5 (5.1)
Malaria	<b>60 (61.2)</b>
Severe anaemia	39 (39.8)
Chlamydia/Syphilis	36 (36.7)
HIV/AIDS	17 (17.3)
Tuberculosis	8 (8.2)
Hepatitis	7 (7.1)

6,349 admissions that met the inclusion criteria, among whom 98 (1.5%) died. This rate is higher than the 1.2% reported by Baldé in Mali in 2019.<sup>[4]</sup> The MMR of 1005 per 100,000 live births is significantly higher than those found by Djongali et al. in Chad in 2017<sup>[5]</sup> and Anki in Congo in 2015<sup>[6]</sup> who reported a MMR of 653/100,000 per live births and 830/100,000 per live births respectively. Our MMR is higher than that of developed countries - estimated at 12/100,000 live births.<sup>[2]</sup> This result demonstrates that maternal mortality remains a major public health problem in Chad.

This mortality particularly affects young women. In this study 57 (58.1%) were aged 24 years and younger. Oyeniyi<sup>[6]</sup> in Sokoto, Nigeria, notes that the 15-24 age group represented 59% of patients. This can be explained by the areas in which the studies were conducted. In rural areas, low school enrolment and poverty encourage cultural practices such as marriage among adolescents. Adolescent pregnancy and childbirth are causes of obstetrical complications which, if unchecked, can lead to maternal death.

Those with less schooling had more obstetric complications. In our study 39.8% women had not attended school which is lower than rates reported by Hatouna in Chad in 2022<sup>[7]</sup> and Baldé in 2019 in Mali.<sup>[4]</sup> This demonstrates the negative role that the lack of literacy plays on maternal mortality. The more educated women are, the better informed they are about the risks related to complications of pregnancy and childbirth, and the more likely they are to attend health facilities.

Lack of schooling is also a factor limiting women's activities. In rural areas, this situation forces women to take care only of household chores. This is supported by our findings that 59.2% of women gave their occupation as housewives which is lower than those reported by authors in Chad in 2022<sup>[7]</sup> and in Mali in 2019,<sup>[4]</sup> respectively 88.89% and 88.5%.

Most of the women who died (79.6%) were married. This can be explained by the fact that pregnancy or childbirth outside of marriage is considered dishonourable by many tribes in Chad. In order to avoid stigmatization, many women are forced to into a relationship.

According to the Chad Demographic and Health Survey, the total fertility rate is 6.2.<sup>[3]</sup> This places Chad among countries with high birth and fertility rates. In this study 27.6% of women were multiparous which is more than the 22.3% reported by Anki in Congo in 2015.<sup>[8]</sup> Multiparity is an established risk factor for maternal mortality. The uterus, after several deliveries, has a reduced capacity to retract. This impacts on its ability to ensure haemostasis in the postpartum period, thus increasing the chance of haemorrhagic complications.

Women with no prenatal contacts accounted for 60.2% of maternal deaths in this study. There was a statistically significant association between the number of contacts and maternal deaths. Women with no contacts were ten times more likely to die than those with four or more contacts [Chi square = 10.61; p = 0.0022]. This is higher than the 54.8% in Mali in 2019<sup>[4]</sup>, and the 47.4% in Chad in 2022.<sup>[7]</sup> This high number of deaths in women with no prenatal contacts can be explained by them missing the information and awareness given during prenatal follow-up. Only 1% of our patients who had had frequent prenatal care (8 contacts) died.

Most of the women, 74.5% (n=73), were from rural areas. Data from the literature show that delay in accessing health care worsens maternal prognosis. The remoteness of households, the impassability of roads during certain months of the year, and lack and cost of transport cruelly hinder access to health facilities.

Sixty-eight (69.4%) of the women who died had been referred from outside BPH; this is less than that found by Baldé who noted 85.6% died after being referred.<sup>[4]</sup> Our high rate of referral could be explained by the lack of qualified personnel and insufficient technical facilities in peripheral health centres. Most of our referred patients were accompanied by unqualified people. Referral is a risk factor for maternal mortality but the earlier patients are referred, the better they can be managed in the referral facilities.

Haemorrhage was the direct cause of death for 67.4% of the women. The literature agrees on the multiplicity of direct causes in the occurrence of maternal deaths. However, there is a divergence of results as to the order of frequency.<sup>[9,10,11]</sup> Studies in Chad by Djongali et al<sup>[5]</sup> and Founsou et al<sup>[12]</sup> found complications of hypertension, haemorrhage and infections as the main direct causes. The high rate of death from haemorrhage can be explained by the long distance travelled to BPH, sometimes without a venous line, the lack of a blood bank at BPH, the refusal

of blood transfusion imposed by certain religions, and delay by parents of patients consenting to provide blood.

Infection remains a significant cause of complications resulting from clandestine abortions and septic deliveries.

Among the indirect causes of death, malaria was the most common with 61.2%. This result complements that of Sayinzoga et al<sup>[13]</sup> who noted that malaria is the main indirect cause of maternal death. This can be explained by the fact that malaria is endemic in Chad and there is a lack of pregnancy monitoring for many women. During prenatal care the prescription of intermittent preventive treatment of malaria limits the occurrence of malaria.

In this study, half (55.1%) of women had a hospital stay of less than 24 hours before they died, which is lower than the 71% of deaths occurring less than 24 hours after admission reported by Baldé.<sup>[4]</sup> This rate is attributable to factors such as the unavailability of blood products. In the case of bleeding emergencies, anaemia must be corrected by blood transfusion. The absence of a blood bank at BPH further complicates treatment.

## CONCLUSION

Maternal death remains a public health problem in developing countries. The MMR in Chad is high in both N'Djamena<sup>[5]</sup> and Bongor. The main characteristics of the deceased patients were: young, uneducated, multiparous and had been referred to BPH. The main causes of death were haemorrhage, infection and hypertension and their complications. Malaria was most common indirect cause. In order to reduce maternal mortality in Mayo-Kebbi Est Province, it is necessary to raise awareness of the importance of schooling for young girls and prenatal consultation, and to improve their access to health care facilities.

**Conflict of interest:** None

All authors participated in the design of this paper and agreed to its submission.

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# Gender-Based Violence: How South Sudan is fighting back

**Nyakomi Adwok**

Institute of Psychiatry, Psychology and Neuroscience, Kings College London.

Correspondence: Nyakomi Adwok  
[nyakomiadwok@gmail.com](mailto:nyakomiadwok@gmail.com)

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## INTRODUCTION

From the first Sudanese civil war in 1955 to cyclical conflicts post-independence, the scarlet cord of violence is inextricably woven into the history of South Sudan. Within this shadow of perpetual destabilisation lies a more entrenched issue: gender-based violence (GBV).

The United Nations (UN) defines GBV as “harmful acts directed at an individual or a group of individuals based on their gender” which is “rooted in gender inequality, the abuse of power and harmful norms”.<sup>[1]</sup> This definition acknowledges the fact that while women and girls suffer disproportionately from GBV, men and boys can also be targeted.

GBV includes a variety of violations from physical, sexual and emotional violence to female genital mutilation and human trafficking. It also encompasses threats of violence, financial abuse, coercion and manipulation.<sup>[2]</sup>

## THE SCALE OF THE PROBLEM

Decades-long conflicts in South Sudan have fostered a culture of impunity that has exacerbated the issue of GBV.<sup>[3]</sup> However, this is not a scourge specific to any particular country. A 2018 analysis of prevalence data conducted by the World Health Organization (WHO) revealed that worldwide; “nearly 1 in 3 women have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence or both”. They also estimate that globally, as many as “38% of all murders of women are committed by intimate partners”.<sup>[4]</sup> Data specific to South Sudan indicate a similarly concerning prevalence.

Even in periods of relative peace, home is anything but a place of safety for South Sudanese victims of GBV. A UN GBV report in 2019<sup>[5]</sup> revealed that, in South Sudan, about 65% of women will experience some form of sexual and gender-based violence (SGBV) such as child marriage and rape in their lifetime. In addition, 33% of women in South Sudan have experienced sexual violence from a non-partner, primarily during attacks or raids. According to the same report, 51% of women in South Sudan have suffered intimate partner violence (IPV). These alarming statistics paint a picture of a stark reality that can only be understood by engaging with victims and the people who support them.

## SITUATION ON THE GROUND: A LAWYER’S PERSPECTIVE

Bol Madut Ayii is a lawyer and co-founder of Screen of Rights, a grassroots South Sudanese human rights organisation. He has worked on prolific cases of gender-based violence, some involving victims as young as nine years old.

In Mr Ayii’s experience, most reported GBV cases in South Sudan are between spouses. The intimacy of the relationship between perpetrator and victim is one of the many barriers that stand between people seeking and obtaining justice. In the event that a victim reports an assault to the police, they are likely to be faced with an inexperienced or poorly trained officer who may send them away to “sort out their issues at home”.

If a case is filed and proceeds to the judicial system, economically disadvantaged victims are often reliant on the charity of lawyers like Mr Ayii, whose pro-bono

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work ensures that they can be represented in court. Even at this stage, further challenges arise. These include trial delays due to high numbers of backlogged cases, threats and intimidation from powerful perpetrators and bribery of court officials. Unfortunately for victims, institutional obstacles and scarcity of resources are only part of the problem.

Lack of awareness of available avenues for support and justice prevents people who may be willing to seek help from doing so, meaning the number of reported cases of GBV in South Sudan is likely the tip of the iceberg. Although many factors contribute to and perpetuate GBV, Mr Ayii postulates that dysfunctional elements of South Sudanese culture play a key role.

### **CULTURAL CONTEXT OF GBV IN SOUTH SUDAN**

Given the impact of culture on family dynamics and gender norms, any discourse on GBV must be culturally informed and contextualised. The 64 ethnic groups of South Sudan<sup>[6]</sup> are unique and distinct from one another but certain norms and social values are widely shared.

#### **The implications of bride price**

Mr Ayii has observed that across many South Sudanese cultures, “GBV starts right from the marriage process” where both parties are coerced into a union that is not of their choosing. Arranged marriages are often negotiated by male relatives, who tend to prioritise the needs and status of the couples’ families above the desires and wellbeing of the couple. This creates fertile ground for resentment to take root within the union and is further complicated by the issue of bride price.

Bride price, although not unique to South Sudan, is an age-old concept that holds cultural significance to many African communities. It refers to forms of wealth paid by a groom or his family to the woman or the family of the woman he is about to marry.<sup>[7]</sup>

Bride price is treasured for what it represents and for the value or status it adds to families. It is widely acknowledged that some men use it to justify mistreatment directed at their wives when they do not meet their demands or expectations. Academic studies have established a link between gender stereotypes and male violence. According to a 2018 study, men who hold patriarchal stereotypes that support male dominance, ‘tend to blame women and children for breaking expected dutiful, submissive behaviours, thereby validating violence as a legitimate form of social control’.<sup>[8]</sup> Within this context, perhaps there needs to be a paradigm shift in the way dowry is regarded in South Sudan.

Mr Ayii states that bride price “should not denote the

value or worth of a woman”. It should instead serve as “a token of appreciation to her birth family, which is in a way, through her marriage, losing a loved, valuable member”. Traditionally, bride price was also intended to enable the bride’s brothers to start families of their own. The interplay of cultural norms and economic incentives further complicates the issue of bride price.

Adhieu Majok, a South Sudanese commentator and activist, has used her significant online platform to address pressing social issues, particularly regarding gender equality. In her 2018 essay, “The Girl and the 500 Cows: The Commodification of Girls in South Sudan”,<sup>[9]</sup> she observed that compared to the modest bride prices of one or two generations ago, marriage has become an expensive, high stakes endeavour for young men and their families. She attributes this to high inflation, poverty, and cyclical conflicts within South Sudan. As a result, “girls and women have become a source of wealth for families” and exorbitant demands continue to fuel communal conflicts and cattle raids, especially in rural areas. It is clear given the current economic situation that the status quo is unsustainable and will only foment further instability and gender inequality in the country.

#### **Gender Beliefs and Norms**

Ms Majok highlights another important issue that underlies most gender-based conflict and violence in South Sudan: the view of women as inferior or second-class citizens. In her personal experience, even in the arena of women’s advocacy, male voices are afforded precedence and attention that is rarely given to their female counterparts.

The viewpoint of women being “less than” has taken root in society partly because the misogyny scaffolding it is espoused by women. Mr Ayii has observed that in many communities, “disciplining” wives through physical violence is not just accepted but even expected, with widely held opinions like “he is not a man if he does not slap me”. It is also not unusual, he adds, for a man to be ridiculed by other men for considering his wife’s views or trying to reason amicably with her instead of dismissing her or resorting to violence.

Many theorize that domestic violence is driven by a desire to gain and maintain control. Michael Kaufman, a Canadian author and gender equality campaigner theorises that domestic violence can be understood as a “weapon to establish and maintain power” and “cope with the fear of not being a real man”.<sup>[10]</sup> The scope of acceptable male behaviour is shaped by culturally informed gender roles. Challenges can arise when men perceive or experience difficulty in fulfilling these roles or in meeting societal expectations of manhood.

Mr Ayii states that widespread unemployment and

joblessness is a significant threat to male identity in South Sudan, especially as so many cultures highlight the role of the man as a provider. Evidence has shown that unemployment is strongly linked with harmful alcohol use and vice versa.<sup>[11]</sup> According to a review by the Southern African Alcohol Policy Alliance (SAAPA) and the South African Medical Research Council (SAMRC), women whose partners were regularly intoxicated were almost six times more likely to experience IPV or GBV.<sup>[12]</sup> GBV is inextricable from wider social issues and any solutions proposed to tackle it must take a holistic approach.

## THE WAY FORWARD

On the 3rd of December 2020, the Judiciary of South Sudan declared operationalisation of the country's first Gender Based Violence and Juvenile Court, supported by the UNDP and the Government of the Netherlands.<sup>[13]</sup> The court aims to operate from a survivor centred perspective by providing dedicated and expedited trials of GBV cases, prioritising the privacy and well-being of victims and holding perpetrators accountable.

While the role of international non-governmental organisations cannot be overstated, South Sudanese have been pivotal in the creation of campaigns and organisations aimed at tackling GBV and empowering women and girls to reach their highest potential. Organisations like Crown the Woman South Sudan (CREW) and Federation of women Lawyers South Sudan (FIDA) promote meaningful gender equality and equity with a long-term view of nation building and development.<sup>[14,15]</sup>

Other organisations like Men4Women are taking the lead in reframing what it means to be a modern South Sudanese man. Men4Women is a non-governmental organisation that engages boys and men in conversations about gender equality and reproductive health. They also organise constructive, innovative behavioural change activities for men that challenge societal stereotypes about the role of a man. These activities include cooking challenges, which empower men with the skills to nourish themselves and defy limitations on what men are allowed or supposed to do.

Such organisations and initiatives recognise a fundamental truth in the quest for harmony in South Sudanese homes and society at large: male allies are essential to the realisation of any progress. Too often, the burden has fallen on women to speak up and advocate for themselves, even though not many are prepared to hear them.

It is no small task to frame new, challenging ideas in a way that people are open to receiving. Mr Ayii has observed from his own experiences in advocacy that individuals and communities are more receptive to positive incentives to change rather than criticisms of what they are doing

wrong.

For example, he challenges opposition to girl's education by pointing to examples of educated South Sudanese women who have gone on to empower and enrich their communities as a result of the opportunities education has afforded them. This, he proposes, is a far more effective strategy than chastising people for not keeping up with the times. Similarly, conversations around gender roles and relations must be framed by understanding and sensitivity without compromising on truth.

## CONCLUSION

GBV is a symptom of a society at dis-ease with itself. Any attempt to address it without considering the cultural context in which it occurs, the beliefs underlying it and the social issues perpetuating it is likely to be futile. Likewise, one-sided solutions that exclude boys and men fail to recognize that GBV is not only a women's issue. It is a societal issue that affects everyone whether they are direct victims or not.

Despite the significant challenges the nation faces, South Sudanese individuals and organisations have demonstrated inspiring initiative and creativity in tackling GBV. The way forward may be difficult but by no means impossible.

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## Improving the health and well-being of women, girls, and young people in South Sudan

June 2023 JUBA, South Sudan – Sweden announced its commitment of 90 million Swedish Krona (\$8.4 million) to UNFPA, the United Nations sexual and reproductive health agency, to implement its fourth Country Programme on sexual and reproductive health and rights, in support of the Government and people of South Sudan. The funding is aimed at helping strengthen reproductive health programmes and responding to gender-based violence.

“Our support aims to contribute to improvements in the health status of women of reproductive age, including young people’s ability to plan their lives through access to family planning information and services, promote women’s empowerment and gender equality, and prevent harmful practices such as child marriage,” said Tomas Brundin, Head of Embassy of Sweden Office in South Sudan.

<https://esaro.unfpa.org/en/news/sweden-invests-84-million-improving-health-and-well-being-women-girls-and-young-people-south>



# Clinical management of rape survivors

Koma Akim 

General and Fistula Surgeon,  
Bor State Hospital, South Sudan

Correspondence:  
Koma Akim [akimkoma@gmail.com](mailto:akimkoma@gmail.com)

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## ABSTRACT

Sexual violence is a worldwide problem that requires a multipronged approach to provide survivors with the basic needs they require. Healthcare workers must know how to manage rape survivors to provide medical care, psychosocial first aid, and referral for further management and assessment if needed. The eight steps in managing rape are: Preparing to receive and offer medical care to rape survivor, Preparing the survivor for the clinical examination, History taking, Forensic evidence collection, Genital examination, Treatment of infection, Counselling and Follow-up.

## INTRODUCTION

Sexual violence is a worldwide problem, particularly in war and natural calamity areas. Rape is a type of sexual violence, a public health concern and a violation of human rights. Rape in war is internationally recognized as a war crime and a crime against humanity. It is also characterized as a form of torture and, in certain circumstances, as genocide.<sup>[1]</sup> It is defined as physically forced or otherwise coerced penetration, even if slight -of the vulva or anus, using a penis, other body parts, or an object.<sup>[2]</sup>

Sexual violence is a complicated matter that requires a multipronged approach to provide the survivors with the basic needs they require. Besides sexual violence being meted out against women and girls, boys and men are also often assaulted during natural and man-made catastrophes.<sup>[3]</sup> Sexual violence predisposes the individual to sexual and reproductive health issues, which, even though treated, have immediate and long-term consequences.<sup>[4]</sup> Therefore, the survivors of sexual assault will require urgent medico-legal, physical, and psychosocial support. As such, the medical and legal systems work together to serve sexual assault survivors and aid in healing.

Healthcare workers, especially those working in the developing world, must be well versed in managing rape survivors to provide medical care, psychosocial first aid, and referral for further management and assessment whenever necessary. Besides, a caring and empathic attitude is essential when offering clinical treatment to rape victims.<sup>[5]</sup> The clinical management of rape depends entirely on the kind of injury sustained by the survivor. See Figure 1. Clinical Management of Rape Algorithm.

## MANAGEMENT OF RAPE

Note that although there are male rape victims we use the female pronoun in this paper. There are eight steps in the clinical management of rape.<sup>[6]</sup> These are:

### Preparing to receive and offer medical care to rape survivor

Hospitals, primary healthcare centres, and units should make a deliberate provision to respond promptly and with empathy to individuals who have been sexually assaulted. In addition, the in-charge of the health facility should ensure that the healthcare team has been appropriately trained and have the essential supplies and equipment required for the job.

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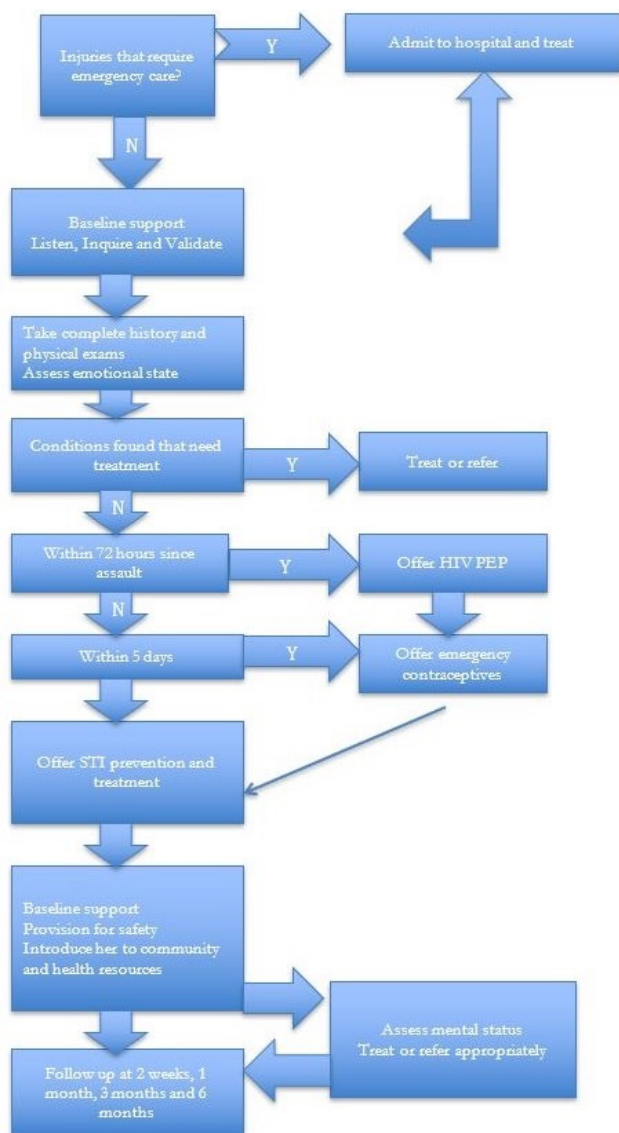


Figure 1. Clinical Management of Rape Algorithm [8]

Key: Y-Yes, N-No

**Preparing the survivor for the clinical examination**

Because the rape survivor has undergone a traumatic experience, the healthcare worker needs to prepare and examine the survivor compassionately and dignifiedly. Informed consent needs to be obtained from the survivor before any examination takes place. The survivor is in charge of the examination process, not the doctor or nurse. Besides, the clinician needs to examine the survivor systematically and comprehensively.

**History taking**

The history must be taken in a quiet room without interruptions and noise. A chaperone and a support person for the survivor should be present during the history taking if she consents to them being there:

1. The survivor’s bio data, time, and examination date are noted.

2. The survivor is asked to describe in her own words, and without interruption, what exactly happened to her.
3. The healthcare worker should check and confirm from the survivor if she sustained any injuries and their locations. The risk for STI and HIV should also be questioned during this time and reassured that this would be treated confidentially. In addition, if the rape occurred recently, the survivor should be asked if she bathed, changed clothes, urinated, defaecated, brushed her teeth, or even combed her hair after the incident, as doing any of these things will compromise the quality of forensic evidence that would be collected.
4. A history of allergy, pre-existing illnesses, vaccination, HIV status, and the last normal menstrual period should be documented since they will guide the most appropriate treatment, counselling and follow-up.

**Forensic evidence collection**

Forensic examination is done to prove or disprove a link between suspects and places or objects. For example, forensic evidence may corroborate the survivor’s story, confirm a history of recent sexual intercourse, and probably identify an attacker. For the success of a case in court, specimen collection, transport, and storage must be done correctly. Evidence should be collected as soon as possible after the incident as time is of great essence, and this should be done preferably within 72 hours of the incident.

**Genital examination**

Before the physical examination, it is essential to ensure that all the equipment and instruments required are ready. After obtaining verbal informed consent and ensuring the survivor is relaxed a thorough examination is conducted. If the initial assessment shows serious complications such as massive trauma to the abdomen, genitalia, chest, neurological deficits, and respiratory distress, the survivor needs to be referred immediately to a health facility where she can be stabilized before the examination can be resumed.

The collection of samples and the examinations are done concurrently, and the samples collected are documented and clearly labelled. Urine for pregnancy tests and high vaginal swabs should be taken simultaneously with the examination. Furthermore, a smear can also be made from a swab to find sperms that will help identify culprits. By identifying the morphology of the sperms and quantity, the time since intercourse can be assessed. It will also add extra information on the crime scene by determining how the offender’s DNA came to be located at the site where it was found.[7] Other tests, such as CXR and abdominal

or pelvic ultrasonography, should be done when a rib fracture or haemoperitoneum is suspected. Finally, the mental state of the survivor, such as normal, withdrawn, depressed, or suicidal, needs to be noted.

### Treatment of infection

The treatment given to rape survivors, whether male or female, depends on how soon after the incident they report to the hospital. In general, survivors are given prophylactic antibiotics to treat sexually transmitted infections, post-exposure prophylaxis to prevent the transmission of HIV, and emergency contraception to prevent pregnancy. In addition, they should receive post-exposure prophylaxis against Hepatitis B and vaccination against tetanus. Wounds and bruises must also be managed by dressing them with povidone-iodine or topical antibiotics.

### Counselling of the survivor

Survivors of rape suffer from psychological and emotional issues; therefore, they need counselling and psychological first aid. Besides, they will require emotional support from trusted family members, friends, and the community. When they experience a severe mental and emotional breakdown, they must be referred to the appropriate professionals for further treatment and support. The survivor is then advised to return to the health facility if there is a question or any health concerns for evaluation.

### Follow up of the survivor

In many cases, perhaps due to the stigma associated with rape and other challenges, the survivor of rape might not return for a follow-up visit. Therefore, the survivor must be provided with sufficient information to support her in making decisions since this might be her only chance. During the follow-up visits, ensure that the survivor has completed vaccination, treatment for sexually transmitted infections, post-exposure prophylaxis for HIV, and contraception. In addition, mental and emotional status is evaluated and referred to a counsellor or treated accordingly.

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# One Stop Centre for the survivors of sexual and gender-based violence at Juba Teaching Hospital

**Busiri Julius Korsuk**

Sexual and Reproductive Health National  
Consultant, UNFPA South Sudan

Correspondence:

Busiri Julius Korsuk [sworo@unfpa.org](mailto:sworo@unfpa.org)

The One Stop Centre at Juba Teaching Hospital offers a package of services for the survivors of sexual and gender-based violence. These include diagnosis and treatment of gender-based violence (GBV)-related injuries and clinical management of rape (CMR), psychological first aid (PFA), and counselling as well as legal support. The Centre provides a safe space, under one roof, for women, men, boys, and girls to obtain professional help and so be able to start healing and re-integrating into their communities.

One female survivor said, “The staff understood the violent situation I had gone through and were helpful. I was given a dignity kit with basic materials for my survival. I got better and let go of the idea of suicide.”<sup>[1]</sup>

A social worker at the Centre said, “We have witnessed a transformation from victims to empowered and well-informed survivors,” ... “After weeks of undergoing counselling and psychosocial support, they come back to the centre and you can barely tell that they were the same women.”<sup>[2]</sup>

In 2017, the United Nations Population Fund (UNFPA) initiated the One-Stop Centre model in Juba as part of their programme to prevent and respond to GBV in South Sudan; there are now 13 Centres in all the ten states of South Sudan managed through various non-governmental organizations in partnership with UNFPA, The State Ministries of Health, State Ministries of Gender, Child and Social Welfare and funded by various donor governments. As well as medical and psychological support for survivors, the Centres train social workers and health staff on how to sensitively meet the needs of survivors. The integrated approach of the One Stop Centres has increased the uptake of GBV services but, most prominently, the convictions of perpetrators of GBV especially sexual violence.

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## Other resource used:

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# SSMJ talks to Data Gordon about Men4Women

Ann Burgess<sup>1</sup> and Data Gordon<sup>2</sup>

1. South Sudan Medical Journal, UK
2. Men4Women Organization, South Sudan

Correspondence:

Data Gordon

[datagordon@gmail.com](mailto:datagordon@gmail.com)

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## INTRODUCTION

Violence against women and girls (VAWG) impacts individuals, communities, and societies across the globe. Data from the World Health Organization indicate that 1 in 3 women worldwide have experienced VAWG in their lifetime, either through intimate partner violence or non-partner sexual violence.

During times of conflict and crisis, violence towards women and girls worsens, leading to increases in sexual exploitation, domestic violence, forced marriage, rape, and transactional and prostituted sex.

Gender-based violence (GBV) in South Sudan is often met with impunity due to societal gender norms that consider women to be under men's control and stigmatize victims of sexual violence. Women are often discouraged from reporting violence for fear of being rejected by their family and community.

While men commit these forms of violence, men are not born violent towards women and girls and not all men commit violence. Many men, in fact, are deeply concerned about the violence that other men commit, and believe that women and girls deserve respect, opportunities, and equality. Men have daughters, mothers, sisters, wives, girlfriends, and friends about whom they care. All around the world, men have important roles to play in helping to create peaceful and safe communities.

**Men4Women** is a national NGO in South Sudan that recognizes the important role that men and boys can play in preventing VAWG. So, **the South Sudan Medical Journal (SSMJ) interviewed Data Emmanuel Gordon, Executive Director of the Men4Women**, to learn more about it.

During times of  
conflict and crisis,  
violence towards  
women and girls  
worsens

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Figure 1. Men-led Cooking Challenge at the South Sudan Council of Churches Ground



**SSMJ:** Data Gordon, thank you for meeting with SSMJ. What are Men4Women’s mission and aims?

**Gordon:** Men4Women’s mission is to promote young people’s sexual and reproductive health and rights, their meaningful participation in the decisions made about their lives, and the importance of making men and boys allies for women and girls.

**SSMJ:** When did Men4Women start in South Sudan, and what does it do?

**Gordon:** Men4Women has been active since 2019 as an initiative and was officially registered by South Sudan Relief and Rehabilitation Commission in January 2022 as a National Non-Governmental Organization. An initial activity was to combat period poverty by raising awareness and improving education about menstruation for men and boys including women and girls.<sup>[5]</sup> While handing out sanitary pads in schools, we begin the conversation about the taboo subject, hoping that both girls and boys will grow more comfortable talking about periods in order to end the stigma and promote women’s health.

“Men4Women’s mission is to promote young people’s sexual and reproductive health and rights, their meaningful participation in the decisions made about their lives.”



Figure 2 Facilitator giving EMAP training for men

**SSMJ:** Data Gordon, what is your role in Men4Women?

**Gordon:** Apart from founding the Men4Women initiative, I was appointed in 2022 as its Executive Director. My role is to help to lead the organization in achieving its vision, mission and objectives and, most importantly, to set up systems and have a team that works towards the promotion of positive masculinity and social norms transformation. I am also tasked to come up with innovative ways to engage men and boys hence the ‘Men Talks’, ‘Talking Circles’, ‘Sexual and Reproductive Health and Rights (SHRH) Camps’, and the ‘Men-led Cooking Challenge’ (Figure 1) among others. You can find details of these groups on our Twitter/X feed - @men4womens. Men4Women works with men and boys to promote ‘positive masculinity’ in schools and the community through a network of Champions.

**SSMJ:** What is a ‘Champion’? How are they trained?

**Gordon:** Under Men4Women, applications were sought from young people who want to be trained and become Champions. Both men and women applied, and thirty young people (24 males, 6 females) were selected and trained as facilitators of ‘Engaging Men on Accountable Practices (EMAP)’ for five days.

After training, they are divided into two groups to continue engaging with community members in two locations. Female facilitators engage female community members per location for eight weeks to collect their voices on GBV and other harmful practices, and these voices informed the engagement of men for sixteen weeks in their respective locations.

Upon completion of the community engagement and impact assessment, both facilitators and community members graduated and were awarded certificates respectively and became known as Champions. (Figures 2 and 3).

The Male Champions continue to be engaged in other Men4Women activities on promotion of positive masculinity as I described above.

**SSMJ:** Tell us more about EMAP

**Gordon:** Engaging Men in Accountable Practices (EMAP) is a one-year primary prevention intervention created by the International Rescue Committee (IRC). It is based on work done in Dadaab Refugee camp.<sup>[4,6]</sup>

Recent research<sup>[6]</sup> indicates that “gender transformative” interventions may reduce men’s intimate partner violence against women. Such interventions challenge deeply held beliefs by men and the power structures that support them.

EMAP is guided by the voices of women and girls. Their testimony regarding types of violence experienced informs the curriculum used with men. EMAP activities are not

intended to diminish tradition or belief systems, but to encourage practices and beliefs that promote respect for women and non-violence.

EMAP's approach aims to transform individual behaviour and targets both women and men, with a special emphasis on enabling men to identify their role in preventing violence against women and become women's allies/Champions.

**SSMJ:** Tell us more about the EMAP curriculum?

**Gordon:** The year-long intervention contains three components:

1. A four-week training of trainers: During this period, staff will become familiar with the EMAP intervention and framework, as well as determine safety strategies, outreach plans, and support structures. After the training, facilitators will introduce EMAP to community leaders, community members, and existing women's groups and leaders.
2. An eight-week session for women which explores GBV and what women want to see change in their community.
3. A 16-week session for the men's curriculum. The men's curriculum groups are intended for men who are not currently violent against women and girls and who are interested in helping to build safer, healthier homes and communities. Over 16 weeks, men move through a process of individual behavioural change, from basic awareness of VAWG to practicing change in different areas of their own lives and acting as allies to women and girls.

There are more details of the one-year curriculum in:

- Introductory Guide (part 1) <https://oxfam.app.box.com/s/u6rhw3ujzv910x19w92e2c213iz8mhpj>
- Training Guide (part 2) <https://oxfam.app.box.com/s/e19x7oysvp1or3zkrflsjvgch1nu8tjb>
- Implementation Guide (part 3) <https://oxfam.app.box.com/s/0dcquzyuw6cbfdlx0e580thdyovu52oa>

**SSMJ:** What evidence is there that EMAP can be successful?

**Gordon:** UNHCR started EMAP in Dadaab Refugee Camp in Kenya. The project involved 480 men and women, gathered community interest, and has resulted in positive and transformative outcomes. The safety of women and girls became a central concern for the community, safe spaces for women were created, and participants became highly regarded and considered as role models in the community. Women reported increased cooperation with household responsibilities by their husbands as well as positive changes in husbands' attitudes towards violence.<sup>[4]</sup>



Figure 3. Facilitator giving EMAP training for women

“EMAP’s approach aims to transform individual behaviour and targets both women and men, with a special emphasis on enabling men to identify their role in preventing violence against women.”

**SSMJ:** How do you reach out to the wider public?

**Gordon:** We reach out to schools and the community through our network of trained Male Champions. This is through our ‘Men Talks’, ‘Talking Circles’, ‘SRHR Camps’, ‘EMAP’ among others, as I mentioned above. Apart from Juba, we’ve expanded our activities to Yambio and Torit (where we trained boda boda riders, and students at Torit Health Science Institute, and hope to expand to other parts of South Sudan. We also reached to Rubkona (Bentiu) through Concern Worldwide to train husbands and mothers’ groups on EMAP. We will be implementing EMAP in Yambio before the end of this year.

**SSMJ:** Will Men4Women and EMAP training be carried out in IDP camps in South Sudan?

**Gordon:** We’ve not ruled out the potential of reaching IDP camps in South Sudan. Should we get support, we’re ready to reach out to the IDP Camps with an EMAP intervention.



- Buying diapers <https://twitter.com/i/status/1699421820774953273>
- Help with cooking <https://twitter.com/i/status/1699097528640188845>
- Showering baby: <https://twitter.com/i/status/1706564260581740761>
- Ironing clothes <https://twitter.com/i/status/1703773777425735964>

More information from: Data Emmanuel Gordon [datagordon@gmail.com](mailto:datagordon@gmail.com)

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1. World Health Organization. 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization. <https://apps.who.int/iris/handle/10665/85239>
2. World Health Organization 2021 Violence against women Prevalence Estimates 2018 <https://www.who.int/publications/i/item/9789240022256>
3. World Health Organization. Violence against women Key Facts 2021 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>
4. International Rescue Committee. Engaging Men in Accountable Practices (EMAP) <https://www.emotiveprogram.org/solution/engaging-men-in-accountable-practices-emap/>
5. VOA Africa. South Sudan's Men Try to Break Menstruation Cultural Taboos [https://www.voaafrica.com/a/africa\\_south-sudans-men-try-break-menstruation-cultural-taboos/6174355.html](https://www.voaafrica.com/a/africa_south-sudans-men-try-break-menstruation-cultural-taboos/6174355.html)
6. Bernard B et al EMAP [https://gbvaor.net/sites/default/files/2022-08/EMAP%20Presentation%20\\_IRC.pptx.pdf](https://gbvaor.net/sites/default/files/2022-08/EMAP%20Presentation%20_IRC.pptx.pdf)

**SSMJ:** Are there any resources/materials that the lessons learnt by Men4Women and the EMAP training can be used by health staff working with GBV in South Sudan?

**Gordon:** In our first EMAP engagement in Juba, we conducted an impact assessment and the findings of the report are helping us extend the programme to other locations. We strongly believe that the lessons learnt can be used by health staff working with GBV in South Sudan. This is because, among others, the findings point out potential signs of GBV and their impact, and how negative social norms hinder GBV reporting.

**SSMJ:** Who supports Men4Women and EMAP training in South Sudan?

**Gordon:** Men4Women is currently supported by UNFPA South Sudan through Amref South Sudan and the Smile Again Africa Development Organization (SAADO).

#### Additional information:

Images: Men4Women own all the photographs and videos, and permission to publish has been given either verbally or in writing by all the subjects.

Videos: See videos on our X feed - @men4womenss. For example:



## Ask the GBV experts

In the course of preparing this issue on gender-based violence, some questions arose, so we asked the two experts in the SSMJ Editorial Board: **Dr Koma Akim**, a general and obstetric fistula surgeon working in Bor State Hospital in South Sudan, and **Dr Nyakomi Adwok**, a psychiatrist with working experience in the UK and Kenya.

### Dr Koma Akim

**SSMJ:** How does one deal with the problem that it often takes time for an abused woman to seek help? She may have to get permission from a male relative or community leader? Is this a problem in South Sudan?

**Dr Akim:** Yes, it is, and it is a complicated issue. In addition to the reasons given, there are others such as the status of women in the South Sudanese society, lack of trust in some healthcare practitioners, sociocultural and economic factors that may encourage violence against women, and the safety and security of the affected woman.

**SSMJ:** Please explain why there is a lack of trust in healthcare practitioners?

**Dr Akim:** Most of the people entrusted with helping abused women are men and this does not give a woman the confidence to seek help from a healthcare centre. One woman explained to me that the reason why few abused women seek help from a One Stop Centre was because the person charged with helping them is often a man, and yet the person who abused them is also a man! She said, "Can a lion be a judge in a dispute between an antelope and another lion?" Although healthcare workers are trained how to counsel abused women and girls without bias, survivors are still reluctant to seek help in time because of the perceived impartiality of the healthcare worker.

**SSMJ:** Which sociocultural issues delay abused women seeking help?

**Dr Akim:** Most women are brought up believing that it is the right of the man to abuse his wife as a sign of love, and not doing so indicates that he does not love her! This is a common belief amongst some of the ethnic tribes in South Sudan. It is not until women are enlightened that spousal abuse is not a sign of love, that they start to develop the courage to seek help. This takes time as a woman needs

to internalize the pros and cons of seeking help and what the repercussions of this decision would be on her future relationship with her husband.

**SSMJ:** What is Female Genital Mutilation (FGM)?

**Dr Akim:** Female genital mutilation is the complete or partial removal of the external genitalia. It is often done for non-medical purposes and is a form of Gender-Based Violence (GBV).

**SSMJ:** Does FGM have any health benefits for women and girls?

**Dr Akim:** No. FGM harms the health and well-being of women and girls and affects them psychologically. It, at times, can lead to death, and in the long term, it affects their sexuality and reproduction.

**SSMJ:** Is FGM a problem in South Sudan? If so, does it occur in all States? What form of FGM?

**Dr Akim:** According to anecdotal evidence, the sixty-four ethnic tribes in South Sudan do not practice FGM in any form. However, an assessment carried out by UNICEF in 2015<sup>[1]</sup> found that the prevalence of FGM in South Sudan was about 1%. These cases of FGM were mainly in Bahr el Ghazal and Upper Nile regions, areas that border Sudan and are inhabited by Sudanese refugees. There is a paucity of information and current statistics on the prevalence of FGM in South Sudan.

**SSMJ:** Is FGM illegal in South Sudan?

**Dr Akim:** Yes, it is illegal in South Sudan. Practicing FGM in any form is a criminal offence. Both the Child Act and the Penal Code prohibit FGM and set out the punishments for perpetrators of FGM.<sup>[2]</sup>

#### References

1. The FGM/C Research Initiative. Distribution of FGM/C across South Sudan <https://www.fgmcricri.org/country/south-sudan>
2. South Sudan: The Law and FGM May 2018 [https://www.orchidproject.org/wp-content/uploads/2019/02/south\\_sudan\\_law\\_report\\_v1\\_may\\_2018.pdf](https://www.orchidproject.org/wp-content/uploads/2019/02/south_sudan_law_report_v1_may_2018.pdf)

**Citation:** Akim and Adwok. Ask the GBV experts. *South Sudan Medical Journal*, 2023;16(4):149-150 © 2023 The Author(s) License: This is an open access article under [CC BY-NC](https://creativecommons.org/licenses/by-nc/4.0/) DOI: <https://dx.doi.org/10.4314/ssmj.v16i4.8>

## Dr Nyakomi Adwok

**SSMJ:** What are the physiological/emotional effects of rape on a woman or girl?

**Dr Adwok:** Injuries, pregnancies and STIs are some of the physical and physiological outcomes associated with rape.

On an emotional level, the impact of sexual violence varies from person to person. There is no right or wrong way to feel afterwards and there is no timeline for “getting over it”

Many survivors experience negative emotions, which can include anger, shame, guilt and anxiety. For many girls and women, rape is a traumatic event. The effects of trauma can include low mood associated with suicidal thoughts, flashbacks, social withdrawal and substance misuse. These can be experienced shortly after the assault or for several years after.

The mental and physical impacts of rape can affect a person’s ability to study, work, maintain relationships or even carry out basic activities of daily life like taking a shower.

**SSMJ:** Do these differ if the abuser is an intimate partner, a person known to the woman, or a stranger such as a soldier?

**Dr Adwok:** Survivors of sexual assault by an intimate partner have been shown to experience psychological symptoms at higher rates than survivors of sexual assaults by strangers. They are also almost twice as likely to suffer from depression or anxiety.<sup>[1]</sup>

**SSMJ:** Do they differ by the age and maturity /parity of the woman/girl?

**Dr Adwok:** Women can experience rape and sexual abuse at any time in their life. Sexual assault occurring at a young age before an individual has developed the mental, physical, emotional, and social resources to cope can be especially devastating. Studies have shown that girls and young women who experience sexual abuse demonstrate early onset puberty and maladaptive sexual development.

They are also more prone to develop obesity and mental or physical illnesses. Girls and young women are also at risk of dropping out of school and teen motherhood.<sup>[2]</sup>

**SSMJ:** How can healthcare practitioners, and a woman’s community and family provide the physiological and emotional support and care needed for an abused woman to heal?

**Dr Adwok:** Apart from assessing for and treating any immediate health concerns, health practitioners also have a responsibility to safeguard their patients and if necessary, refer them to organisations that can offer practical support.

One way that all these groups can support abused women is to respond to their disclosures in a compassionate, non-judgmental way. This includes the disclosure of the assault and their response to it. People respond to assault in many different ways, some of which can be surprising. It is important for those close to victims to know there is no script or timeline they have to follow.

One overlooked way families can support a victim of sexual assault is to acknowledge and address their own response to their loved one’s suffering. This can be done with a therapist or a trusted friend or family member.

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# The reality of GBV: The story of a South Sudanese girl child in Kenya

## **Nyajuok Tongyik Doluony**

Women and Girl Child Advocate, Rtd US Army Captain, and author of “I Am My Mother’s Wildest Dream”

*Nyajuok Tongyik lived in Dimma Refugees Camp, Ethiopia, was resettled in the US, and experienced a child marriage and domestic and family abuse. She founded the ‘I Am Nyatongyik’ foundation <https://iamnyatongyikfoundation.my.canva.site/> and was recently in South Sudan promoting her book and working with UNFPA.*

### Correspondence:

Email: [iamnyatongyik@gmail.com](mailto:iamnyatongyik@gmail.com)

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During the “I Am My Mother’s Wildest Dream” East Africa book tour, strangers shared their stories with us, and soon we learned that my story is not mine alone; it is a reflection of others’ stories and our society as a whole. Most of the stories we have heard fall into one of the following categories: child marriage, ghost marriage, lack of girl child education, or gender-based violence. Regardless of how little they shared, the pain was the same, and they were all asking for more out of life. “I Am My Mother’s Wildest Dream” shines a light on a misogynistic culture that has kept many people in the dark, and people are beginning to speak up and out against it. Sooner or later, we will be forced to listen and rewire our thoughts on the future of the South Sudanese girl child.

Below is a story of a young South Sudanese girl from Nairobi, Kenya, at our first book launch:

“Today, I accepted the unfathomable reality that I have been rejected. I’ve tried so many times to further my education by applying for not one or two scholarships but twenty! And guess what? I was rejected by all the institutions. Sometimes I wonder if I deserve this type of rejection or if it’s just how life is. Life has perpetually humbled me to the point where sometimes I cry my eyes out. Other times I sit dumbfounded before retreating to a quiet place to get my mind in check so as not to go crazy. Still, other times, I just keep quiet and let the storm pass. No matter what path I decide to take, I can’t help but ask myself, “Where is my silver lining?” I haven’t seen it, so I’ve decided that luck is not on my side.

Do not get me wrong, it’s not that I feel entitled or that I think I am more deserving than others; it’s just that I really wish things would work out for me, just for once. I have an insatiable craving to join a university and earn a degree like most other people. However, a year ago, I reduced my expectation of earning an undergraduate degree to settling for a diploma. I began taking various training courses and received several certificates. During that time, I learned that even a certificate is worth a lot more than just sitting at home waiting on well-wishers and do-gooders to help me get back into school.

“What is your plan if education doesn’t work for you?” they asked. “It is good to have several plans in life,” they said. The thing is, education was my only plan, but instead, I found myself seated listening to my aunties plant the idea of marriage inside my head. It’s not just any ordinary marriage; it’s a Western world kind of marriage. You know the kind with a wedding gown, ring, a possible visa, and to top it all off, my potential husband would be a Europe-based South Sudanese man. The age or age difference is never really considered; the major requirement is for the man to be well-loaded.

I am against the “Bride for Sale” idea, but if you are a South Sudanese girl like me, then you are well aware that your life decisions are not yours to make. Especially when your uncles and aunts join forces and pitch a very compelling get-rich-quick scheme to your parents. So, I watched as they created a Facebook account because previously, I did not have one, or rather, I did not see the need to have one. At the time, I was oblivious to the fact that it was the market where bridal auctioning happens.

After my Facebook account was created, a professional photo shoot ensued. After all, suitors cannot buy what they cannot see. My not-so-bare yet still tantalizing photos with eye-catching captions made their intended rounds on social media. Of course, my family was careful not to make it obvious that this was a quest to find me a wealthy husband. However, their plan worked! One after the other, the thirsty men fell into their intricately woven trap. These men began asking for my hand in marriage, but unbeknownst to them, the goal was to bag as much money as possible. So, those who came to negotiate with nothing but love and a few coins were immediately blocked. The young men who were recent graduates from university yet had no jobs were also rejected. And to make it worse, the men residing in Juba were told they had nothing to offer.

Being from a well-known reputable family makes the “sale” more expensive and increases the number of suitors. In addition, your height and beauty double the price. If you can cook, know your role as a wife, not talk back, stay indoors, cover yourself in a respectable manner, and hide all your allowances from other men, then you are the jackpot! Lastly, keeping the “yolk” intact only for the chosen one makes you even more desirable and increases your value.

I hated every single part of this marriage tradition, but speaking up would indicate that my mother did not raise me well. It would also earn her backlash and a few blue and black beatings, and I could not let that happen. The auction intensified and expanded to TikTok! My family members recorded me live carrying out tasks. I was instructed to do things like cooking kop, wal-wal, kisra, mula kombo, and many other traditional foods. They say the greatest way to a man’s heart is through the stomach, but I didn’t want anything to do with a man, let alone being in his heart. I wanted to be like fingernails on a chalkboard so he would reject me and save me from this misery.

Eventually, the auctioneers gave their bids, and I was sold to the highest bidder – an eighty-year-old man. He had sons and daughters older than myself and needed someone to take care of him in his old age. Regardless of age and health status, he ticked off the qualifications of being rich, living in Europe, and the other things my family had decided on.

The wedding took place when he arrived at Kakuma

Refugee Camp. When I tell you this man couldn’t even stand without aid, I mean exactly that! But money made my family members blind, deaf, and even mute, so I was disposed of.

After the wedding, I was taken to my husband’s house, and that is where I now reside. My biggest task and challenge is taking care of him under extreme scrutiny from his five older wives and children. They all constantly remind me without fail that I was disposed of and should never have high expectations of my life changing. My relatives only pick up my calls to ask me when I will be sending them money. I cannot complain because I am not allowed to. And I should laugh through my misery since a rich man’s joke is always funny. I find no purpose in living.

Sadly, this is a reality for most of the South Sudanese girls who have either not gone to school or have stopped schooling for various reasons such as lack of school fees. The uncles and aunts will not help clear your fees but will have the audacity to find you a husband. Your parents will not see the injustices done to you because of the bragging rights they will obtain in society as a result of your marriage. Your siblings will not speak up for you because they will now enjoy the privileges of rubbing shoulders with the rich. You are given just enough to ensure you do not think outside the box and find out that it is a scheme, a charade, and that you will be dependent on the husband and his family for the rest of your life. Your rights are now limited by he who holds your power.

So, my question is, what if God had given me just one scholarship? Would my life be less than the hell I am currently living? Rejection is redirection, they say, but I wish I was redirected to a classroom in a university which would groom me to become a lawyer so that I can fight the injustices thrown at me and the female gender at large by dystopia.”

This is one girl’s story, but she is not alone. As a society, we have been called to do better because we know better. Around the world, we have seen young girls grow up to become politicians, lawmakers, teachers, doctors and businesswomen. Why not your daughter, sister, niece, or cousin? Instead of serving tea under a mango tree and waiting for a man to ask for her hand in marriage, you can help her dream big. The sky is no longer the limit, but for them, reaching for the sky is good enough.

# 16 Days of Activism Against GBV

**Rita Martin Lopidia**

Executive Director

Eve Organization for Women

Development

*Eve Organization is a South Sudanese Women's Organization founded with the aim of contributing towards social change through promoting gender equity and equality, social justice, peace and security of women.*  
<https://evesouthsudan.org/>

Correspondence:

[rita.martin@evesouthsudan.org](mailto:rita.martin@evesouthsudan.org)

The 16 Days of Activism against Gender-Based Violence (GBV) is an annual campaign spearheaded by the Ministry of Gender, Child and Social Welfare in partnership with UN agencies, INGOs and Civil Society Organizations. The campaign starts with a march around Juba, and in other cities in South Sudan, on 25th November, the International Day for the Elimination of Violence against Women, and runs through to International Human Rights Day on the 10th December.

GBV in South Sudan is exacerbated by the harmful cultural gender norms, gender stereotypes, and the long history of conflicts. These factors are often used to justify violence against women and girls and the perpetrators are mainly men. So, to resolve GBV, it is crucial to engage men and boys.

The 'Eve Organization for Women Development' is under the protection pillar of the UNSCR 1325, and during the 16 Days of Activism Against GBV, it joins the campaigns of the Ministry of Gender, Child and Social Welfare. It also runs an online campaign encouraging everyone to get involved. It amplifies the voices of survivors, and encourages donors to support women's organizations and activists and strengthen women-led movements. Eve supports all acts that empower survivors, reduce and prevent violence against women and girls, and protect women's rights in South Sudan.

Eve does the following on GBV:

- Conducts live radio talk shows to discuss the issues of GBV and provide information on the referral pathway for survivors of sexual and gender-based violence (SGBV), aiming to raise awareness about GBV and SGBV, provide a platform for survivors to share their experiences, and educate the public on how to access support and services.
- Provides training to the ABC level courts using the UNDP GBV pocket guide to ensure that courts have the necessary knowledge and tools to effectively handle GBV cases in a sensitive and informed manner.
- Organizes ABC forums to bring chiefs, individuals, and organizations together within the community to work together and advocate for increased implementation of GBV legislation.
- Trains and engages boys and men, in the areas of GBV and gender equality (GE). This involves educating males on how GBV and GE impact their communities and the importance of promoting protection for those who are most at risk.
- Provides training and education on GBV legislation, human rights, and gender equality to police and prison staff, with the aim of equipping them with the necessary skills and knowledge to handle GBV cases in a professional and effective way.
- Manages cases of victims of GBV through the Psychological Focal Points (PFPs) in the locations where it implements its activities. Eve provides comprehensive support to GBV survivors and refers them to the established network of referral pathways to ensure that they receive the necessary care and resources to recover from their traumatic experiences.

Eve works with the Ministry of Gender, Child and Social Welfare to effectively tackle persuasive GBV issues by supporting safe house and has donated beds and furniture for the safe house in Kapoeta. Eve strongly advocate and lobby on combating GBV with decision-makers and policymaker leaders by meeting them face to face and training them on GBV regulations and protection.

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# Resources on gender-based violence / violence against women and girls related to South Sudan

The resources are grouped under:

1. Government of South Sudan
2. United Nations and related agencies
3. Non-governmental organizations/charities: local and international
4. Miscellaneous
5. Articles in academic journals

## 1. Government of South Sudan

- South Sudan Ministry of Gender, Child and Social Welfare: <https://mgcsw.gov.ss/>
- GBV sub-cluster: National Humanitarian Response to Gender based Violence 2019-2021 [https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ss\\_gbv\\_sc\\_strategy\\_2019-2021.pdf](https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ss_gbv_sc_strategy_2019-2021.pdf)

## 2. United Nations and related agencies

WHO:

- Violence against women: Overview-Impact- WHO response. [https://www.who.int/health-topics/violence-against-women#tab=tab\\_1](https://www.who.int/health-topics/violence-against-women#tab=tab_1)
- Global Database on the Prevalence of Violence Against Women [https://srhr.org/vaw-data/data?countries\[\]=SSD](https://srhr.org/vaw-data/data?countries[]=SSD)
- Infographics <https://www.who.int/multi-media?healthtopics=675ffc5f-6492-4d27-9b23-ba549986bdca>
- International Day for the Elimination of Violence against Women <https://www.who.int/news-room/events/detail/2022/11/25/default-calendar/international-day-to-eliminate-violence-against-women>
- WHO Resource package for strengthening countries' health systems response to violence against women 2021 <https://www.who.int/publications/i/item/WHO-SRH-21.5>
- WHO Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition, 2021 <https://www.who.int/publications/i/item/9789240039803>

UNHCR:

- Gender based violence. UNHCR actions <https://www.unhcr.org/uk/gender-based-violence.html>
- Toolkit of key relevant materials for GBV specialists and non-specialists working with or for UNHCR. <https://www.unhcr.org/gbv-toolkit/> Resources GUIDANCE AND TOOLS | UNHCR GBV Toolkit
- Sexual and Gender Based Violence (SGBV) Types of SGBV: Services to address SGBV <https://help.unhcr.org/southsudan/violence-or-abuse/sexual-and-gender-based-violence-sgbv/>

## UNFPA:

- UNFPA population data 2022 <https://www.unfpa.org/data/transparency-portal/unfpa-south-sudan>
- World Population Dashboard <https://www.unfpa.org/data/world-population/SS>
- State of Midwifery <https://www.unfpa.org/data/sowmy/SS>
- UNFPA in South Sudan news <https://southsudan.unfpa.org/en> and UNFPA South Sudan | UNFPA South Sudan Quarter 1 Newsletter 2023
- Early Marriage and Unintended Pregnancies the ‘Elephant in the Room’ in Camp for Displaced Persons, South Sudan UNFPA ESARO | Early marriage and unintended pregnancies the ‘elephant in the room’ in camp for displaced persons, South Sudan

## UNDP:

- Donors elevate awareness and response to gender - based violence in South Sudan July 2022 <https://www.undp.org/south-sudan/stories/govt-un-donors-elevate-awareness-and-response-gender-based-violence-south-sudan>

## UNICEF:

- Addressing gender-based violence in emergencies. <https://srhr.dspace-express.com/bitstream/handle/20.500.14041/3451/Addressing-GBV-in-Emergencies-Why-GBV-Matters.pdf?sequence=1>

## UN Human Rights Council’s commission on South Sudan:

- Report highlights widespread sexual violence against women and girls 21 March 2022 <https://www.ohchr.org/en/press-releases/2022/03/south-sudan-un-report-highlights-widespread-sexual-violence-against-women> and <https://reliefweb.int/report/south-sudan/south-sudanese-rape-survivors-left-without-help-let-alone-justice-un-experts> and [https://www.ohchr.org/sites/default/files/2022-03/A\\_HRC\\_49\\_CRP\\_4.pdf](https://www.ohchr.org/sites/default/files/2022-03/A_HRC_49_CRP_4.pdf)

**3. Non-governmental organizations/charities: local and international**

## MSF:

- Sexual violence: <https://www.msf.org/sexual-violence>. Good for general intro
- Assault and care characteristics of victims of sexual violence in eleven Médecins Sans Frontières programs in Africa. What about men and boys? 2020 <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0237060>
- Central African Republic story <https://www.msf.org/central-african-republic-visual-journey-through-ongoing-conflict>
- Democratic Republic Congo report <https://www.msf.org/sexual-violence-democratic-republic-congo>
- International Rescue Committee What is gender-based violence – and how do we prevent it? | International Rescue Committee (IRC)
- Crown the Woman South Sudan. Who We Are: <https://crownthewoman.org/who-we-are/>
- Grassroots Justice Network. Federation of Women Lawyers South Sudan. <https://grassrootsjusticenetWORK.org/connect/organization/federation-of-women-lawyers-south-sudan/>.
- Engaging Men and Boys Through Accountable Practices (EMAP) [https://www.emotiveprogram.org/solution/engaging-men-in-accountable-practices-emap/#:~:text=A%20one%20year%20primary%20prevention,the%20International%20Rescue%20Committee%20\(IRC\)&text=The%20framework%20for%20EMAP%20is,lives%20of%20women%20and%20girls](https://www.emotiveprogram.org/solution/engaging-men-in-accountable-practices-emap/#:~:text=A%20one%20year%20primary%20prevention,the%20International%20Rescue%20Committee%20(IRC)&text=The%20framework%20for%20EMAP%20is,lives%20of%20women%20and%20girls)



- I Am NyaTongyik Foundation <https://iamnyatongyikfoundation.my.canva.site>
- Men4Women [https://www.voaafrica.com/a/africa\\_south-sudans-men-try-break-menstruation-cultural-taboos/6174355.html](https://www.voaafrica.com/a/africa_south-sudans-men-try-break-menstruation-cultural-taboos/6174355.html)
- South Sudan Women Empowerment Network (SSWEN). Initial Assessment and Mapping: Reducing Inequality and Gender-Based Violence in South Sudan. [https://www.eeas.europa.eu/sites/default/files/south\\_sudan\\_womens\\_empowerment\\_network\\_6.12.2021\\_1\\_002.pdf](https://www.eeas.europa.eu/sites/default/files/south_sudan_womens_empowerment_network_6.12.2021_1_002.pdf)
- Resource and Support Hub UK Aid Introduction to safeguarding – RSH South Sudan. Infographic South Sudan: <https://safeguardingsuppoorthub.org/essentials>

#### 4. Miscellaneous

- Rape, Abuse, & Incest National Network: Sexual Violence in Six African Nations (Democratic Republic of the Congo (DRC), Egypt, Kenya, Nigeria, Tanzania, and Uganda.) 2021 Rape, Abuse, & Incest National Network <https://www.rainn.org/sites/default/files/Africa-Report-2022.pdf> See Exec Summary & DRC p20 by Dennis Mkwega
- Panzi Hospital DRC: Photo report Victims into Survivors <https://panzifoundation.org/> and Dennis Mkwega <https://panzifoundation.org/dr-denis-mukwege/>

#### 5. Recently published articles on GBV in South Sudan in other academic journals

- Liebling H, Barrett H, Artz L. South Sudanese refugee survivors of sexual and gender-based violence and torture: health and justice service responses in northern Uganda. *International journal of environmental research and public health*. 2020 Mar;17(5):1685. <https://doi.org/10.3390/ijerph17051685>
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## GBV Educational/Training Resources

### World Health Organization. Caring for women subjected to violence: a WHO curriculum for training health-care providers, revised edition, 2021

<https://www.who.int/publications/i/item/9789240039803>

The revised edition includes 4 new modules three of which are for health managers to assess and strengthen health facility readiness and one module, which is for managers and providers to support prevention of violence against women. [The earlier content published in 2019 remains unchanged.](#) The 2021 edition is aimed at creating an enabling health systems environment for health workers to provide quality care to women subjected to violence.

Related tools:

- [Handouts](#) 28 pages (?use handout 1a for back cover if get permission)
- [Resources for exercises](#) 110 pages
- [Slide Deck](#), 315 pages, PDF, 14 MB (All sessions)

### World Health Organization. Addressing violence against women in pre-service health training: integrating content from the Caring for women subjected to violence curriculum, 2022

<https://www.who.int/publications-detail-redirect/9789240064638>

This guide is a companion to [Caring for women subjected to violence: a WHO curriculum for training health care providers](#), which consists of 17 training sessions on the health response to violence against women: 13 for health care providers and 4 for health managers. Both publications were produced to support countries' efforts to strengthen the competencies of health workers or health worker students to provide safe, quality, survivor-centred care for women subjected to violence. It also includes illustrative case studies from select countries that have integrated this content into their health worker curriculum.

This companion document is designed to provide pre-service health training programmes, such as in medical, nursing and midwifery schools, with the knowledge and resources to better prepare their students to care for women subjected to violence. Specifically, it provides guidance to help integrate and adapt sessions from the WHO curriculum into pre-service health worker education programmes, providing guidance on planning, developing and implementing this. Comprehensive, survivor-centred training can enhance the knowledge and improve the attitudes of health practitioners and health worker students and increase their readiness to care for survivors of violence.

## World Health Organization. Resource package for strengthening countries' health systems response to violence against women 2021

<https://www.who.int/publications/i/item/WHO-SRH-21.5>

To support and guide countries and partners to strengthen a health systems response to address violence against women, WHO has produced several tools, including:

- clinical and policy guidelines;
- implementation handbooks and manuals;
- training curriculum;
- evidence-based policy, prevention and intervention strategy packages.

The resource package consolidates these documents to support countries to develop or update their national or subnational guidelines, protocols, standard operating procedures, health provider training materials, and multisectoral action plans to prevent and respond to violence against women.

The resource package is also intended to be used for training and sensitization of policy-makers, advocates, health care providers and managers of services and programmes to address violence against women.

### Why the food crisis is worse for women and girls

Globally, women play a huge role in ensuring everyone has enough to eat — with responsibility for an estimated 90% of all food purchases and preparation — yet gender inequality means that they are more vulnerable to hunger and malnutrition. In times of crisis, it's women who forgo the most meals. Between 2019 and 2021, the gender gap in food insecurity more than doubled from 49 million to 126 million, as the COVID-19 pandemic impacted livelihoods, income, and access to nutritious food for women.

Meanwhile, the number of pregnant and breastfeeding adolescent girls and women suffering from acute malnutrition has risen by 25% since 2020 in the 12 countries hit hardest by the global food and nutrition crisis, according to UNICEF.

In response to this escalating situation, a new initiative, the Gender Nutrition Gap was launched at last week's Women Deliver conference in Rwanda. Supported by over 40 organizations including FHI 360, Kirk Humanitarian, Action Against Hunger, and Stronger Foundations for Nutrition, the campaign aims to coordinate action across the sector in eight areas identified as contributing to the gap. Areas of focus include tackling social norms that discriminate against women and girls, food system market failure, and the need to prioritize women and girls' nutrition in humanitarian crises.

Global development organizations involved in fighting hunger are educating women and adolescents on their nutritional needs, supporting them to make decisions around the crops they plant and how household income is spent, and involving male family members in conversations about gender roles.

[https://www.devex.com/news/devexplains-why-the-food-crisis-is-worse-for-women-and-girls-105940?access\\_key=&utm\\_source=nl\\_newswire&utm\\_medium=email&utm\\_term=article&utm\\_content=text&mkt\\_tok=Njg1LUtCTC03NjUAAAGNK6-nTCKr-l-P6EWy1BUt5bXg-lglHjcUwAtdcdWQ4aBDgY0VuxwgOF2A3FS9lRiMYavc7J4BvDT6pcg-AiAPA6WgVD1W3gajrN8Qe6QY\\_g-ZqFY](https://www.devex.com/news/devexplains-why-the-food-crisis-is-worse-for-women-and-girls-105940?access_key=&utm_source=nl_newswire&utm_medium=email&utm_term=article&utm_content=text&mkt_tok=Njg1LUtCTC03NjUAAAGNK6-nTCKr-l-P6EWy1BUt5bXg-lglHjcUwAtdcdWQ4aBDgY0VuxwgOF2A3FS9lRiMYavc7J4BvDT6pcg-AiAPA6WgVD1W3gajrN8Qe6QY_g-ZqFY)

# Harmful traditional practice – Infant Oral Mutilation

Dear Editor,

While a lot of awareness is being raised about Female Genital Mutilation (FGM), not many people have heard or know about Infant Oral Mutilation (IOM). Before I say more about IOM itself, the word mutilation needs to be understood. By definition, mutilation is a surgical procedure performed in the absence of a medical indication. Body piercings, tattooing and scarification are examples. In most cases, these are cosmetic and done in adulthood. However, IOM is done on young infants and involves gouging out an unerupted embryonal tooth. It is called germectomy in dental jargon. IOM is the cause of acute complications such as septicaemia and tetanus, and even death. It can also lead to serious dental problems in adulthood and theoretically be the cause for the spread of blood-borne infections such as HIV and Hepatitis B and C.

The practice of IOM is common and unique to East African countries and is called by various names. For example, it is called Ebiino in Uganda and Lugbara in Sudan. In Bor Town of Jonglei state in South Sudan and surrounding areas, it is called 'Hooth'. The reason caregivers of young children resort to IOM has been studied in Uganda and is considered to be because of the unerupted deciduous tooth being mistaken for maggots eating the body.<sup>[1]</sup> A casual look at the number of children who undergo the procedure of 'Hooth' shows that it is very common in the town of Bor and is not specific to one tribe or ethnic group of the country. In a yet to be published study 86% of children under 6 months of age admitted to the hospital had undergone IOM/Hooth. Further study is required to find out the enormity of the problem in all states of South Sudan.

The Dental Associations of other East African countries have signed a 'Call to Action' to stop the practice.<sup>[2]</sup> While there are not many dentists in South Sudan, the Ministry of Health and the associations of medical and dental professionals should aim to eradicate IOM by collecting data about the practice,<sup>[3]</sup> signing the "Call to Action" and take steps to eradicate the practice. More studies on understanding why people resort to this practice would help to plan communication on behaviour change. Until then every educated person in South Sudan needs to warn friends and relatives about the harmful effects of IOM.

**Dr Shalini Ninan Cherian,**

Principal, Jonglei Health Sciences Institute.

[principal.jhsi@gmail.com](mailto:principal.jhsi@gmail.com)

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## Dr Bashir Aggrey Abbas Meseka

Dr Bashir Aggrey Abbas Meseka died in Juba, South Sudan on 24 October 2023 following a short illness. At the time of his death, Dr Bashir was working as a senior medical officer at the new Gudele General Hospital.

He was born on 7 September 1987 in Juba. His father was Aggrey Abbas Meseka Bashir of the Moru Muruba Clan, Tore Wande Boma, Mundri West County and his mother Monica Andrea Lado Lojong of the Pojulu Meremyresuk Clan, Bereka Boma, Lainya County.

Dr Bashir started primary education in 1994 at El Etihad Model Primary School and completed secondary school in 2005 at Abdallah Karim Aldin Model School in Khartoum, Sudan. He was then admitted to the University of Juba College of Medicine and graduated in 2013 with a degree of Bachelor of Medicine and Surgery.

He worked at Juba Teaching Hospital from 2013 – 2017, as well as at Juba Medical Complex as a medical officer. He served as the Medical Director of Yambio General Hospital from 2019 – 2022 and AMREF Maridi County Hospital from 2022 – June 2023.

During these times, Dr Bashir attended several training courses including the Management of Trauma and Burnt Patients organized by ICRC – South Sudan; Basic Urology at the Urology and Nephrology Centre – Al-Mansoura University, Cairo, Egypt; and the Technology of Acupuncture and Tuina training at the Xiyuan Hospital of China Academy of Chinese Medical Science.

Dr Bashir will be missed by the medical fraternity in South Sudan. He was single and described, by his colleagues, as a humble and hardworking young doctor.



“A humble and hardworking young doctor.”

### Gender-Based Violence in Schools - A Silent Epidemic

[https://allafrica.com/stories/202307190083.html?utm\\_campaign=daily-headlines&utm\\_medium=email&utm\\_source=newsletter&utm\\_content=aans-view-link](https://allafrica.com/stories/202307190083.html?utm_campaign=daily-headlines&utm_medium=email&utm_source=newsletter&utm_content=aans-view-link)

Africa, like many regions across the globe, faces significant challenges in addressing school-related gender-based violence (SRGBV). It is estimated that one in three girls in sub-Saharan Africa will experience some form of SRGBV during her school years, according to UNESCO. Alarming statistics show that between 46% and 78% of adolescent girls in African schools have experienced some form of SRGBV. This can have a devastating impact on girls' education, mental health, and overall well-being and perpetuate a cycle of gender inequality. As a result, many girls are forced to avoid school, perform below their potential, or even drop out altogether. This violence has a significant negative impact on the educational achievements of female students. SRGBV encompasses various forms, including sexual harassment, assault, bullying, discrimination, and harmful gender norms.

The consequences of SRGBV are far-reaching.

However, the Brave Movement <https://www.bravemovement.org/> is emerging as a global force. The organization aims to end all forms of sexual violence against children. It operates on the belief that survivors should be at the forefront of the fight against sexual violence, and their voices and experiences should guide the movement's actions. The Brave Movement, launched in April 2022, has experienced significant growth. The movement has members from around the world, with particularly rapid growth in Africa and Europe.



## Dr Peter Lado Aggrey Jaden



Death has robbed the South Sudanese Medical Fraternity of one of the finest professionals with high integrity. Dr Peter Lado Aggrey Jaden died in South Africa on 28th August, 2023 from complications developed after a successful open-heart surgery.

At the time of his untimely demise, he served as a Consulting Health Advisor at the World Bank in South Sudan.

Dr Jaden was born to the renowned freedom hero, the late Aggrey Jaden and the late Sarah Reja. He joined University of Nairobi and graduated with a Bachelor Degree in Pharmacy 1989 and additionally attained other qualifications including certifications in Monitoring and Evaluation and Health Economics. At the time of his death, he was pursuing Master of Public Health degree at Kenyatta University.

Dr Jaden started work as a senior Hospital Pharmacist at the Coast General Hospital in Mombasa, Kenya and later partnered with friends to open a successful private Pharmaceutical Company in the South Coast and Mombasa – Omaera Pharmaceutical Ltd, which is one of the leading Manufacturers in Kenya. He worked for Population Services International (PSI) South Sudan, Christian Health Association of Sudan (CHAS) as head of HIV/AIDS Programmes, Health In Africa (HIA), International Finance Corporation (IFC) World Bank Group, and then the World Food Programme from 2016 to 2017. While at the Ministry of Health in South Sudan (Mar 2009 - Apr 2010), Dr Jaden facilitated the South Sudan Household Survey and Health Facility Mapping Exercise. His contributions to the field of health and community development were immense, and his work extended far beyond the boundaries of his profession.

His career was marked by deserving awards and recognitions for his outstanding contributions to society. Dr Jaden was a Senior Health Policy Advisor between January 2014 and March 2016, playing a key role in the establishment of the South Sudan General Medical Council (SSGMC) and developing regulatory guidelines and tools.

From October 2017 to the time of his passing, Dr Jaden worked with the World Bank in South Sudan, supporting health programmes, contributing to the preparation and supervision of lending operations, collaborating with various stakeholders, and supporting health training programs.

Dr Jaden was involved in several community and sport activities. He was chairperson of the Medical and Anti-Doping Commission of the South Sudan National Olympic Committee and supported associations of people living with HIV in South Sudan. He was also an active golfer and a member of multiple golf clubs. Some of his unfulfilled endeavours include the Aggrey Jaden Foundation Library proposed to be constructed in Loka Round, Lainya County, South Sudan.

World Bank friends and colleagues say, “As you rest peacefully with the angels above, we mourn your loss; and we celebrate your memory as a warm friend, a trusted colleague, a true development professional and a South Sudanese patriot. We will always remember you, too, for your actions: how you supported us in reaching out to the Juba Children’s Hospital and helping us organize our donation drive; how you pulled together health promotion activities for World Bank team members especially during the difficult times of the COVID19 pandemic, and how you supported our outreach activities to members of the medical community in Juba.”

He was married to the late Lady Justice Beatrice Thurania Jaden and together they had three children, Dr. Reja Kendi, Lesuk Lado, and Koome Thurania.

# Tales of **LALA**

No to GBV



Every effort has been made to ensure that the information and the drug names and doses quoted in this Journal are correct. However readers are advised to check information and doses before making prescriptions. Unless otherwise stated the doses quoted are for adults.